Elite Marketing Group
An Insurance Designers member since 1986

Long Term Care Quote Request

Name of 1st Insured		DOB/Age	State of Application
□ Male □ Female	□ Tobacco □ Non-Tobacco	Height Weight	Height and weight is optional. Underwriting may differ from quote if not within limits
Medical history / Prescription Medications			□ Preferred Discount □ Married
Business Owner? Tax Filing: □ C-Corp □ S-Corp □ Partnership □ Sole Proprietor			
Name of 2nd Insured		DOB/Age	State of Application
□ Male □ Female	□ Tobacco □ Non-Tobacco	Height Weight	Height and weight is optional. Underwriting may differ from quote if not within limits
Medical history / Prescription Medications			□ Preferred Discount
Business Owner? Tax Filing: □ C-Corp □ S-Corp □ Partnership □ Sole Proprietor			

□ Daily Benefit $_____ □ Monthly Benefit $_____	**Elimination Period**	**Benefit Period**

Riders

INFLATION □ 3% compound □ 5% compound □ 5% Simple □ None

□ **Waiver of Home Care EP**

□ **Spouse Shared Care**

□ **Spouse Waiver of Premium**

□ **Survivorship**

□ **Restoration of Benefits**

□ **Return of Premium**

□ **Nonforfeiture Benefit**

Agent Name	Email, Fax or Mailing Address to send proposals:

Send to Kristy Fulton— kfulton@elitemktg.net or Fax to 713-574-2756 call with questions 713-507-1035 or Paul Davis– pdavis@elitemktg.net or Fax to 512-257-9701 call with questions 512-900-4591.

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Long-Term Care Health Questionnaire

If you are interested in coverage for you and *your spouse*, please complete *one questionnaire for each*.

Name: _____ **Date of Birth:**_____ **Resident State:**____

Height _____ **Weight** _____ **Tobacco Usage in last 12 months: Yes☐ No☐**

Single ☐ **Married** ☐

Please list all medications and reason for use (if you need more space, please write on a separate page):

_____

_____

Please list all medical conditions not listed above that were diagnosed in the last 5 years or for which you see a doctor for follow-up (if you need more space, please use a separate page):

_____

_____

Please list any surgeries in the last 10 years including date, reason for surgery, and date of last follow-up and/or physical therapy visit:

_____

_____

Please list any conditions that affect or have the potential to affect your mobility or your ability to perform what are called the activites of daily living (eating, dressing, bathing, etc.) or that affect or have the ability to affect your ability to perform what are called the instrumental activities of daily living (driving, talking on a telephone, using a computer, etc.):

_____

_____

If you have ever been declined for long term care insurance, please list date and reason:

_____

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