LTC ILLUSTRATION REQUEST FORM

Please complete all fields to help us get you the most accurate illustration(s).

Once completed, fax the form to Chuck Barretto at 949-225-7119

AGENT/BROKER INFORMATION:

Name: _____ / Date: _____

Company Name: _____ / Phone: _____

Address: _____

Fax: _____ / E-mail: _____

CLIENT INFORMATION:

Client 1 Name: _____ / Date of Birth: _____

Client 2 Name: _____ / Date of Birth: _____

General Health: Height Weight Tobacco Use (Quit Date, if NO)

Client 1 Data: ___ft.____in./ _____lbs./ NEVER, NO, YES / _____date quit

Client 2 Data: ___ft.____in./ _____lbs./ NEVER, NO, YES / _____date quit

Medical Condition / Date Diagnosed / Rx Medication / Dosage / Frequency

Client 1 med #1: _____/_____/_____/_____/_____

Client 1 med #2: _____/_____/_____/_____/_____

Client 2 med #1: _____/_____/_____/_____/_____

Client 2 med #2: _____/_____/_____/_____/_____

What is the relationship between #1 and #2? _____

LTC PLAN INFORMATION:

State of Residence (Illustration is for what state?): _____

Type of Coverage: Joint / Individual

Maximum Daily / Monthly Benefit Amount: _____

Elimination Period: 0 / 30 / 90

Benefit Period: 2yr / 3yr / 4yr / 5yr / 6yr / Lifetime

Qualification: Qualified / Non-Qualified

Inflation Protection: Simple / Compound / None

Premium Mode: Annual / Semi-Annual / Quarterly / Monthly

Pay Options: Single Pay / 10-Pay / Pay to 65 / Lifetime

LTC Carrier Preference (Optional): _____

Riders / Options / Notes (Please Specify):