C.O.R.E. GROUP USA

Request For LTC Quote

Agent Name _____ State in which policy will be issued _____

CLIENT INFORMATION

Client Name _____

Age _____ Date of Birth_____ Height _____ Weight _____ Or is Client Proportionate? ☐ Yes ☐ No

Any tobacco use in the last 5 years? ☐ Yes ☐ No Date Quit _____

Seen a Doctor for physical exam in the past 12 months? ☐ Yes ☐ No Any hospitalization in the past 5 years? ☐ Yes ☐ No

If yes, please list type and date of surgeries, prognosis, lengths of hospital stays, etc.:

_____

_____

_____

_____

Please list all medications; including dosages and reason taken:

_____

_____

_____

Is Client married? ☐ Yes ☐ No If yes, is spouse also applying? ☐ Yes ☐ No (Complete seperate form for spouse)

POLICY INFORMATION

Daily Benefit $ _____ or Monthly Benefit $ _____

If uncertain, please indicate where client will most likely recieve care and how much of the bill they would like to coinsure:

_____

Assisted Living Benefit: ☐ 50% ☐ 75% ☐ 80% ☐ 100%

Home Care: ☐ 50% ☐ 75% ☐ 80% ☐ 100%

Elimination Period: ☐ 30 ☐ 60 ☐ 90 ☐ 180 ☐ 365 days

Benefit Period: # of years ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 10 ☐ Lifetime

Inflation protection: ☐ None ☐ 5% Simple ☐ 5% Compounded ☐ CPI Compound

Payment Method: ☐ Single Pay ☐ 10-Pay ☐ 20-Pay ☐ Paid Up @65 ☐ Lifetime Pay

Billing Method: ☐ Monthly PAC ☐ Quarterly ☐ Semi-Annual ☐ Annual

Preferred Riders, Additional Comments, etc.:

_____

_____

*Complete entire form to **SUBMIT** or **FAX** to 480-991-8885, attn: CaseDesign Team*

Requests for quotes will be prepared within 24 business hours.