LFS INSURANCE SERVICES

LTC Quote Request Form

Please return form to TBunn@LFSUS.com or fax to 360-694-4007

Important: Please complete all sections prior to submission. Incomplete information will result in inaccurate assessments from insurance carriers.

Producer Information

Name: _____ LTC Training Complete: ☐ Yes ☐ No

Email (for response): _____ Phone Number: _____

Address: _____ Quote Needed by: _____

Client Information

Client 1 Name: _____ DOB: _____ Gender: ☐ M ☐ F

Height: _____ Weight: _____ ☐ Married ☐ Single State: _____

Tobacco Use: ☐ Yes ☐ No Last used: _____

Medical History

Diagnosis	Date of Onset	Date of Last Symptom	Medications

Client 2 Name: _____ DOB: _____ Gender: ☐ M ☐ F

Height: _____ Weight: _____ ☐ Married ☐ Single State: _____

Tobacco Use: ☐ Yes ☐ No Last used: _____

Medical History:

Diagnosis	Date of Onset	Date of Last Symptom	Medications

Long -Term Care Benefits

Benefit	Home Health Care	Benefit Period	Inflation Protection	Additional Riders
$_____ ☐ Daily ☐ Monthly	☐ _____% Elimination Period # of Days _____	☐ 2 Year ☐ 3 Year ☐ 4 Year ☐ 5 Year ☐ 6 Year	☐ None ☐ 3% Compound ☐ 4% Compound ☐ 5% Compound	☐ Shared Care/Benefits ☐ Restoration of Benefit ☐ Return of Premium ☐ 0-day Home ☐ Elimination Period

Target Annual Premium: $_____

Partnership Plan Requested? ☐ Yes ☐ No