

"I NEED A QUOTE" FOR IMMEDIATE ASSISTANCE, CALL 800-842-7799

Normal / Prepare by End of Next Business Day

Please call me to discuss my case.

Agent Name _____
(Please circle your contact preference) PHONE FAX EMAIL

TELL US ABOUT YOUR CLIENT(S)

Appointment Date & Time _____ State _____ Previous Decline Self Spouse

Name _____ DOB _____ HT _____ WT _____ Smoker Yes No

Spouse's Name (if applying) _____ DOB _____ HT _____ WT _____ Smoker Yes No

Health History Within Last 5 Years (by applicant) _____

Medications including dosage and length of treatment (by applicant) _____

Does your client want the ability to receive care at home? Yes No

Does your client want cash benefits when care is provided by voluntary caregivers (family/friends)? Yes No

Does your client want a rate guarantee? Yes No

OPTION 1 - Design A Plan Within Client's Budget

Client can spend up to \$ _____ per month for: Self & Spouse Self Only

OR

OPTION 2 - Quote On Plan With Following Benefits & Options

Carrier Preference _____ Most Competitive Carrier

Maximum Daily Benefit (NH) _____ Plan Duration _____ Years Unlimited

Elimination Period (EP) (Days) 0 30 60 90 180 365 Waive EP for HHC (circle if important)

Assisted Living (% of NH) 50% 60% 70% 80% 100%

Professional HHC (% of NH) 100% 200% 300% (Basic paid at 1/2 of Prof)

Monthly HHC Option - Benefits paid on monthly (instead of daily) basis

Inflation Options: Compound Lifetime 2.5% 3% 3.5% 4% 4.5% 5%

5% Compound-10 Years 5% Compound-20 Years 5% Compound-Double Max

5% Simple Guaranteed Purchase Option

Spouse Related Options Shared Care Survivorship Waiver of Premium Spouse Security

Return of Premium Full Less Claims

(Benefits for Uninsured Spouses)

Pay Period Lifetime 10 Pay 20 Pay Pay to Age 65

Benefits and options may vary by carrier and state.

FAX COMPLETED FORM TO 866-863-8608