(800) 943-ADVOCATE

Agent Name: _____ Date: _____

Phone: _____ Email: _____

Long Term Care Insurance Quote Request Form ***Please Fax or send via Secure Email***

For Processing please remit to: Fax: 614.471.7196 || Secure Email: carolyn@ialtc.com

Assets looking to protect? $ _____ Budget available? $ _____ mo / yr

Single Premium Dump? Y / N

Retirement Income Estimate (Social Security + pensions…etc)? $_____ mo

Client's care goals: Stay at Home: Y / N Care by Family Members: Y / N

Does this client own a business with 3 or more employees? Y / N *(Additional discounts/concessions available)*

Client:
Name: _____State: _____

DOB: _____ Ht: _____ Wt: _____

Tobacco Use: Y / N
Quit? Y / N If Yes, when? _____

Spouse:
Name: _____ State: _____

DOB: _____ Ht: _____ Wt: _____

Tobacco Use: Y / N
Quit? Y / N If Yes, when? _____

Client	Spouse/Partner		
☐	☐	1.	Do you currently require human assistance or supervision in order to perform any of the following activities: bathing, dressing, eating, getting out of bed/chair, walking, or toileting?
☐	☐	2.	Have you had Cancer? If yes: Stage cancer reached? _____ Metastatic? Y / N Treatments finished date: _____ Reoccurrence? Y / N
☐	☐	3.	Diabetes: If yes: Type: _____ A1C: _____ Fasting Blood Sugar: _____
☐	☐	4.	Do you have any scheduled or recommended treatments or surgeries? (List below)
☐	☐	5.	Family History of Alzheimer's or Dementia? *(Does not preclude client from coverage)*
☐	☐	6.	Have you ever been diagnosed or treated by a health care professional for any major medical condition(s)? Please list below.
☐	☐	7.	Are you taking Rx medications? If yes, please list all medications below, along with condition each was prescribed for and dosage amounts.

Details to "YES" answers above and ALL medications taken

Client: _____

_____

_____

_____

_____

_____

_____

Spouse/Partner: _____

_____

_____

_____

_____