

# LTCl Quote Request Form

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please print legibly.

## Agent Information

Name: \_\_\_\_\_  
Date Proposal Needed: \_\_\_\_\_ Email: \_\_\_\_\_  
Phone Number: ( ) \_\_\_\_\_ Fax Number: ( ) \_\_\_\_\_  
Company Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Suite/Floor: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Please designate if the above address is a  residential or  commercial address.

Would you like your quote  EMAILED  FAXED or  MAILED to you? Please see note at bottom of form\*.

## Supplies Requested with Quote

Send Supplies?  Yes  No Are You Appointed with Level Four and the Carrier?  Yes  No  
Carriers: \_\_\_\_\_ States: \_\_\_\_\_  
 Brochures  Software  Appointment Papers  Medicare Guides  Apps  
 Specimen Policies  Shoppers Guides  Underwriting/Rate Guides  Other \_\_\_\_\_

*Some carriers require pre-appointment before applications can be taken. Please make sure you are appointed with Level Four before taking an application.*

## Client Information

Client Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_  
Marital Status: \_\_\_\_\_ Is the Spouse Applying?  Yes  No  
If "YES" Spouse's Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_  
Client's Resident State \_\_\_\_\_ State where application will be signed \_\_\_\_\_  
*If an application is signed in a state other than the resident state, a valid reason must be given.*

## Policy Options

Carriers with whom you are appointed through Level Four: \_\_\_\_\_  
Carrier quote(s) requested: \_\_\_\_\_

## Standard Plan Options

Nursing Home Daily Benefit: \$ \_\_\_\_\_ Nursing Home Benefit Duration: \_\_\_\_\_ Years.  
HHC Daily Benefit Amount: \$ \_\_\_\_\_ Home Health Care Benefit Duration: \_\_\_\_\_ Years.  
Elimination Period: \_\_\_\_\_ Days

**Inflation Protection Option** (please circle one of the following): Simple Compound CPI None  
*In most cases the nursing home and home health care benefit durations will be the same. In most cases the home health care benefit amount will be either 50%, 75%, 80% or 100% of the nursing home benefit depending on the carrier.*

## Notes:

---

---

---

---

*\*Level Four will only quote a standard rate unless a detailed medical history is provided along with a quote request form. Give us a call and we will fax you a medical history form.*

Fax to Level Four at (214) 969-1919. Call (214) 969-1888 with any questions.

# LTCl Medical History Form

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please print legibly.

## Agent Information

Name: \_\_\_\_\_  
Date Proposal Needed: \_\_\_\_\_ Email: \_\_\_\_\_  
Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_ Fax Number: ( \_\_\_\_\_ ) \_\_\_\_\_  
Company Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Suite/Floor: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## Client Information

Client Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Smokes Cigarettes?  Yes  No Smokes Cigars?  Yes  No  
If you have quit smoking how long has it been? \_\_\_\_\_

## Hospitalizations in the Past 10 Years

(1) Dates: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
Cause: \_\_\_\_\_ Result: \_\_\_\_\_  
(2) Dates: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
Cause: \_\_\_\_\_ Result: \_\_\_\_\_  
(3) Dates: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
Cause: \_\_\_\_\_ Result: \_\_\_\_\_

## Medications Currently Taken

Medication: \_\_\_\_\_ Taken for: \_\_\_\_\_ Dosage: \_\_\_\_\_ x/Day: \_\_\_\_\_  
Medication: \_\_\_\_\_ Taken for: \_\_\_\_\_ Dosage: \_\_\_\_\_ x/Day: \_\_\_\_\_  
Medication: \_\_\_\_\_ Taken for: \_\_\_\_\_ Dosage: \_\_\_\_\_ x/Day: \_\_\_\_\_  
Medication: \_\_\_\_\_ Taken for: \_\_\_\_\_ Dosage: \_\_\_\_\_ x/Day: \_\_\_\_\_  
Medication: \_\_\_\_\_ Taken for: \_\_\_\_\_ Dosage: \_\_\_\_\_ x/Day: \_\_\_\_\_

## Medical Conditions Treated in the Past 10 Years

Condition: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Condition: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Condition: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Condition: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Fax to Level Four at 214-969-1919. Call 214-969-1888 with any questions.