LTC Quote Request Form

Not an application for insurance. This form is used exclusively to gather specific information on a proposed insured's medical history and other factors that may impact underwriting and rating classifications.

ASH BROKERAGE

Advisor Name: _____

Phone: (_____) _____ Fax: (_____) _____

Email: _____

Proposed Insured's Name: _____

Date of Birth or Age: _____ ☐ Male ☐ Female Tobacco? ☐ Yes ☐ No State: _____

Known health conditions: _____

Please remember to include an LTC Prescreening Questionnaire.

Married? ☐ Yes ☐ No

Spouse Insured's Name: _____

Date of Birth or Age: _____ ☐ Male ☐ Female Tobacco? ☐ Yes ☐ No State: _____

Known health conditions: _____

Please remember to include an LTC Prescreening Questionnaire.

Premium Tolerance: _____/year Investable Assets: _____

Please check: ☐ Daily ($50–$400) / ☐ Monthly ($1,500–$12,000): $_____

Benefit Period (2, 3, 4, 5 or 6 years): _____

Benefit Increase Rider: ☐ Yes ☐ No If yes, ☐ compound ☐ 3% ☐ 5%

Elimination Period: ☐ 20 days ☐ 30 days ☐ 90 days ☐ 100 days ☐ 180 days ☐ 365 days

Riders: Please check if you would like this rider included at an additional cost.

Nonforfeiture	Waiver of Home Care Elimination Period	Survivorship
Shared Care	Return of Premium (*Riders vary with each carrier)	

Other Information: _____

Not all are available with each product we offer. We will quote as close to the option you select based on the availability of the product.

LTC Prescreening Questionnaire

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Client/Applicant A: _____

DOB: _____ Height: _____ft. _____in. Weight: _____lbs Smoker? ☐ Yes ☐ No

Client/Applicant B: _____

DOB: _____ Height: _____ft. _____in. Weight: _____lbs Smoker? ☐ Yes ☐ No

Is there is a history of any of the following conditions for either of the persons named above:

Client A YES	Client B YES	Question	Client A YES	Client B YES	Question	Client A YES	Client B YES	Question
☐	☐	1. Abnormal Blood Pressure	☐	☐	18. COPD / Emphysema	☐	☐	35. Memory Loss
☐	☐	2. AIDS/ARC	☐	☐	19. Coronary Artery Disease	☐	☐	36. Multiple Sclerosis
☐	☐	3. Alcohol Abuse	☐	☐	20. Crohns Disease	☐	☐	37. Muscular Dystrophy
☐	☐	4. ALS	☐	☐	21. Dementia	☐	☐	38. Myasthenia Gravis
☐	☐	5. Alzheimer's Disease	☐	☐	22. Depression/Anxiety	☐	☐	39. Neurogenic Bladder
☐	☐	6. Amputation	☐	☐	23. Diabetes	☐	☐	40. Neuropathy
☐	☐	7. Anemia	☐	☐	24. Dizziness/Vertigo	☐	☐	41. Organ Transplant
☐	☐	8. Aneurysm	☐	☐	25. Drug Abuse	☐	☐	42. Organic Brain Syndrome
☐	☐	9. Arthritis	☐	☐	26. Eye Disease	☐	☐	43. Osteoporosis
☐	☐	10. Asthma	☐	☐	27. Heart Attack	☐	☐	44. Paralysis
☐	☐	11. Atrial Fibrillation	☐	☐	28. Hepatitis	☐	☐	45. Parkinson's Disease
☐	☐	12. Bipolar/Manic Depression	☐	☐	29. Hodgkins Disease	☐	☐	46. Peripheral Vascular Disease
☐	☐	13. Cancer* (see below)	☐	☐	30. Joint Replacement	☐	☐	47. Rheumatoid Arthritis
☐	☐	14. Cardiomyopathy	☐	☐	31. Kidney Failure	☐	☐	48. Scleroderma
☐	☐	15. Carotid Artery Disease	☐	☐	32. Leukemia	☐	☐	49. Seizures
☐	☐	16. Cerebral Vascular Disease	☐	☐	33. Lupus	☐	☐	50. Stroke or TIA
☐	☐	17. Congestive Heart Failure	☐	☐	34. Lymphoma	☐	☐	51. Tremor

Provide name and dosage of ALL medications being taken and the condition being treated *(refence question number if applicable)*

Details for Applicant A Question #		**Details for Applicant B** Question #	
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Any others? If so, please describe: _____

Are you currently using oxygen, a wheelchair, crutches, cane or a walker? _____

Are you currently on disability or do you have a handicapped parking sticker? _____

Have you been declined for LTC insurance in the past? If so, when and reason? _____

Do you have any surgeries or tests scheduled or pending? _____

Are you currently taking any narcotic medications? _____

Are you currently receiving physical therapy? _____

Advisor Name: _____

Phone: (_____) _____ E-mail: _____

Be sure to include this form with an LTC Quote request.

*For cancer, please include type, stage/grade, any recurrence or lymphnode involvement, date of last treatment.