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benefit design associates, ltd.

LONG TERM CARE QUOTE REQUEST FORM

INFORMATION **Date:** _____

Name: _____

Male ___ Female ___ Date of Birth: _____ Smoker ___ Non Smoker ___

Spouse's Name (if Applicable): _____

Male ___ Female ___ Date of Birth: _____ Smoker ___ Non Smoker ___

Address: _____City: _____ State: _____ Zip: _____

Telephone: _____

Fax: _____

E-mail: _____

Preferred Method of Contact: _____

COVERAGE REQUESTED

Nursing Facility Monthly Benefit: _____

Cost of Living: ___5% Compound ___5% Simple ___None

Home Care: ___100% ___80% ___50%

Benefit Period (yrs): _____ Elimination Period: _____

MEDICAL HISTORY

Height: _____ Weight: _____ Spouse's Height: _____ Spouse's Weight: _____

Name	Medical Condition	Date Diagnosed	Treatment/Therapy (Medication, Chiropractor, Follow-up visits...)

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