



Long Term Care Insurance Quote Request Form

Please print legibly, failure to do so may result in incorrect or delayed quote delivery.

Date: _____

AGENT INFORMATION

Name: _____ Telephone: _____ Ext.: _____

Agent License Number (mandatory for FL and CA producers): _____

Company Name: _____ Affiliation: _____

Email: _____

CLIENT INFORMATION

Name: _____ Male Female

Date of Birth: _____ Age: _____ Smoker: Yes No

Marital Status: _____ Is Client's Spouse Applying? Yes No
Discounts may apply even if spouse is not applying.

If spouse is applying, please provide the following information:

Spouse's Name: _____ Male Female

Date of Birth: _____ Age: _____ Smoker: Yes No

Client's Resident State: _____ State where application will be signed: _____
If an application is signed in a state other than the client's resident state, a valid reason must be provided.

POLICY OPTIONS

Carriers You Would Like Quoted: _____

Target Premium/Desired Premium Range: _____

Nursing Home Monthly Benefit: \$ _____ Nursing Home Benefit Duration: _____ Yrs. (1,2,3,4,5,6, lifetime)

Home Health Care Coverage: 50% 75 - 80% 100%

Elimination Period: _____ Days

Inflation Protection Option: Compound _____ % None

Riders: Shared Care Waiver of Elimination Period for Home Care Survivorship

Joint Waiver of Premium Nonforfeiture

I would like CBS to call me to discuss available long term care insurance options.

Special Notes: _____

Please note: CBS will only quote a standard rate unless a completed Medical History Form is provided along with this Quote Request Form.

If you have additional questions, please contact CBS Brokerage at 763.450.1870.

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