NORTHERN STATES BROKERAGE, LLC

Request For LTCI Quote

Agent Name: _____ **Phone Number:** _____

Print Please! **Fax Number:** **Email:**

1 Benefit
$ _____
☐ DAILY BENEFIT
☐ MONTHLY BENEFIT*

2 Home-Community
_____ %
50% - 100% of Benefit

3 Elimination Period
_____
0 – 100 DAYS
☐ 0 DAY HHC*

4 Benefit Period
☐ 2 YEAR
☐ 3 YEAR
☐ 4 YEAR
☐ 5 or 6 YEAR
☐ LIFETIME

5 Inflation Protection
☐ SIMPLE
☐ COMPOUND
☐ NONE

*not available with all plans

Additional Riders:
☐ SHARED CARE/SHARED BENEFIT*
☐ RESTORATION OF BENEFITS*
☐ SURVIVORSHIP*
☐ 10 YEAR PREMIUM PAYMENT*
☐ TO AGE 65 PREMIUM PAYMENT*
☐ OTHER: _____

Primary Insured	Spouse/Partner
Primary Insured: _____	Spouse/Partner: _____
Date of Birth: _____	Date of Birth: _____
Last Complete Physical: _____	Last Complete Physical: _____
Last Tobacco Use: _____	Last Tobacco Use: _____
Height: _____ Weight: _____	Height: _____ Weight: _____
Surgeries/Hospital Stays in last 5 years: _____	Surgeries/Hospital Stays in last 5 years: _____

Have you been treated for any of the following conditions in the past 5 years?
(*Check all that apply*)

Primary Insured		Spouse/Partner
☐	High Blood Pressure (controlled for 6 months? Yes/No)	☐
☐	Heart Attack, Angina, Angioplasty or Atrial Fibrillation	☐
☐	Stroke or TIA (single, multiple) (Date: _____)	☐
☐	Arthritis (Rheumatoid, Osteo)	☐
☐	Diabetes (Treatments: Type I Insulin Dependant, Type II Oral Meds, Diet & Exercise)	☐
☐	(Neuropathy, Retinopathy)	☐
☐	Osteoporosis (T-score _____; Compression Fractures)	☐
☐	PSA (men) _____	☐
☐	Cancer (Type: _____; Last Treatment: _____)	☐
☐	Fibromyalgia (Chronic Fatigue; Employment Status: _____)	☐
☐	Anxiety/Depression (situational; last hospitalization _____)	☐

Other Health Issues or Details of Above Conditions:	Other Health Issues or Details of Above Conditions:
_____	_____
_____	_____

Prescription Medications	Dosage	Taken For	Prescription Medications	Dosage	Taken For

STATE OF CLIENT RESIDENCE & ADD'L AGENT NOTES: