NORTHEAST BROKERAGE

Life | Annuity | LTC | DI

Long-Term Care Illustration Request Form

Producer Information

Name: ___________________________ Email: ____________________ Fax: __________________________

Date: _____________ Date needed by: ___________ State: _________ Send Via: ☐ E-mail ☐ Fax ☐ Mail

Insured information

Insured information:

Name: ________________________ DOB: ______________ ☐ Male: ☐ Female Smoker?

☐ Married ☐ living with partner ☐ Single Living alone

Name of spouse/ partner: _____________________________ DOB: ________ State: _____ ☐ Male ☐ Female

License number: _____________________ License expiration: _________________

Current coverage in force: ☐ Life ☐ Disability ☐ Long term care ☐ Annuity

Existing long term care coverage

☐ None ☐ Group LTC ☐ Individual LTC Elimination period________ monthly/ daily benefit_________

Benefit period_____________ Company________________ Replacing coverage: ☐ Yes ☐ No

Insured Medical information

Height: _______ Weight: _________ Blood Pressure: ___________________Cholesterol:____________________

Medications- list name and dosage of medication and Condition being treated:

____

____

____

Medical conditions or hospitalization in last 10 years

____

____

____

Family History of Alzheimer's, Parkinson's, or dementia: ☐ Yes ☐ No ***If yes Explain***

____

____

____

Northeast Brokerage
www.nb-bga.com
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Insured medical information continued:

1. Heart conditions: Coronary artery, valve, heart muscle, high blood pressure, rhythm disorders? ☐ Yes ☐ No
2. Tobacco/ Marijuana : Yes No- Date last used, Type, frequency, method :____________________________________
3. Peripheral vascular disease: Carotid artery stenosis, blockage of leg arteries? Aneurysms, other? ☐ Yes ☐ No
4. Cancer or Tumors: Organ involved: ____________ Tumor type: __________ Stage/Grade: ___________ ☐ Not applicable
5. Mental health disorders: anxiety, depression, ADHD, bipolar, panic disorders, PTSD, other? ☐ Yes ☐ No
6. Lung disorders: asthma, sleep apnea, chronic bronchitis, emphysema, sarcoidosis, pulmonary fibrosis, other? ☐ Yes ☐ No
7. Brain disorders: stroke, TIA, multiple sclerosis, seizures, dementia, neuropathy, global amnesia, other? ☐ Yes ☐ No
8. Diabetes: Type-I Type-II Treatment___________ Diagnosis date: _______ Largest HgA1c ______ ☐ Not applicable
9. Muscles disorders: myasthenia Gravis, muscular dystrophy, polymyositis, dermatomycosis's, other?
10. Blood disorders: Anemia-type ___________ clotting disorders-type __________ other? _____________ ☐ Not applicable
11. Rheumatoid arthritis, Grave's disease, thyroiditis? ☐ Yes ☐ No
12. Systematic lupus, Ankylosing spondylitis, chronic fatigue syndrome? ☐ Yes ☐ No
13. Kidney inflammation, protein or microalbumin in urine? Pituitary disorders, Adrenal disorders? Other? ☐ Yes ☐ No
14. Liver disorders- hepatitis, fatty liver, abnormal liver function tests, other? Pancreatitis? Other? ☐ Yes ☐ No
15. Diverticulosis, weight-loss surgery, esophageal disorders, GERD, ulcerative colitis, Crohn's disease, other? ☐ Yes ☐ No
16. Arteritis, vasculitis, chronic pain syndrome, bone or joint disorders, ear, nose and throat disorders? ☐ Yes ☐ No
17. Substance use: Type:_________________ date of any rehabilitation:__________ Relapse date:__________ ☐ Not applicable
18. Any condition not listed?

Please explain any information to which you answered yes or to which more information should be provided:

____
____
____
____

Policy request information:

Daily/ Monthly benefit amount: ___________________

Benefit period: ☐ 2 yr. ☐ 3yr. ☐ 4yr. ☐ 5yr.

Elimination Period: ☐ 30 Day ☐ 60 Day ☐ 90 Day ☐ 180 Day ☐ 365 Day

Riders: ☐ Compound inflation ☐ Simple inflation ☐ shared care ☐ Waiver of HHC Elimination period

☐ Restoration of benefits ☐ Additional cash benefit ☐ other

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