NORTHEAST BROKERAGE

Life | Annuity | LTC | DI

Long-Term Care Illustration Request Form

Producer Information

Name_____ **E-Mail**_____**Fax**_____

Date: _____ **Need by:** _____ **State:** _____ **Send via:** ☐ **E-mail** ☐ **Fax** ☐ **Mail**

Insured Information

Name _____**DOB**_____**State**_____ **Sex** ☐ **Male** ☐ **Female**

Height _____ **Weight** _____ ☐ **Married** ☐ **Living with Partner** ☐ **Single Living Alone**

Nicotine Use ☐ **Current – Type** _____ ☐ **Former – Type & Date Quit** _____ **Never** ☐

Name of Spouse/Partner _____**DOB**_____**State**_____ **Sex** ☐ **Male** ☐ **Female**

Height _____ **Weight** _____

Nicotine Use ☐ **Current – Type** _____ ☐ **Former – Type & Date Quit** _____ **Never** ☐

Medications – List Name & Dosage of Medications and *Condition Being Treated with theMedication*:

Medical Conditions or Hospitalizations in the Last 10 Years:

Family History of Alzheimers or Dementia: ☐ **YES** ☐ **NO**
If yes, list relationship and age at onset.

Policy Quote Information

Daily/Monthly Benefit Amount: _____

Benefit Period: ☐ **2 Yr** ☐ **3 Yr** ☐ **4 Yr** ☐ **5 Yr** ☐ **6 Yr** ☐ **7 Yr** ☐ **10 Yr**

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**

Existing Coverage Information

Coverage: ☐ **NONE** ☐ **Group LTC** ☐ **Individual** **Elimination Period:** _____ **Monthly/Daily Benefit:** _____
Benefit Period: _____ **Company** _____ **Replacing Coverage? Y/N** _____

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