



HEARTLAND LTC REQUEST FOR QUOTE

DATE: _____

Agent Name _____ State of Client's Home: _____ Licensed? Y / N Date of Last CE _____

Phone Number: (_____) _____ State of Sale/Application: _____ Licensed? Y / N Date of Last CE _____

Client's Name: _____ Smoker: Y / N

Partner's Name: _____ Smoker: Y / N

Date of Birth: _____ Height: _____ Weight: _____

Date of Birth: _____ Height: _____ Weight: _____

MEDICAL INFORMATION: Please fill out the following information as it pertains to either client to assist in prequalifying the rate class.

Conditions of Primary Insured	Date Diagnosed	Treatment/Therapy (Medication, Chiropractor, Follow-up visits...)
Name of Medication- Primary Insured	Dosage	Reason Taken / Date Started

Conditions of Spouse / Companion	Date Diagnosed	Treatment/Therapy of Condition (Medication, Chiropractor, Follow-up visits...)
Name of Medication- Spouse / Companion	Dosage	Reason Taken / Date Started

BENEFITS: Check or Fill In Plan Design we will match your request as closely as possible to fit your needs.

<p>State Specific</p> <p><input type="checkbox"/> Non Partnership <input type="checkbox"/> Partnership <input type="checkbox"/> Quote Both</p> <p>Claim Style</p> <p><input type="checkbox"/> Reimbursement <input type="checkbox"/> Indemnity <input type="checkbox"/> Cash <input type="checkbox"/> Mixture of Above</p>	<p>Quote Needed... Traditional Long Term Care</p> <p>Daily or Monthly Benefit: \$ _____ Comprehensive (100%) Coverage or Other: _____ Benefit Pool/Years Per Person: _____ Elimination Period: _____ Inflation: 5% Compound, 5% Simple, GPO, None, Other _____ Payment: Lifepay, Pay to age 65, 10 Pay, Single Pay, Other _____</p> <p>Riders: (Circle)</p> <p>Shared Care Survivorship Dual Waiver of Premium Calendar Day EP Waiver of HHC EP Return of Premium Less Claims Non Forfeiture Restoration of Benefits Full Return of Premium</p>	<p>Quote Needed... Hybrid Product</p> <p><input type="checkbox"/> Life with LTC <input type="checkbox"/> Annuity with LTC <input type="checkbox"/> Quote Both</p> <p>Solve Using...</p> <p>Premium Submitted _____ Coverage Per Month _____ Years of LTC covered _____</p> <p>AML Training Complete? Y/N Match to Traditional Quote? Y/N</p>	<p>Additional Supplies Needed</p> <p><input type="checkbox"/> Product Brochures <input type="checkbox"/> Product Application <input type="checkbox"/> Full Sales Kit <input type="checkbox"/> Other: _____</p> <p>Send by:</p> <p><input type="checkbox"/> Email <input type="checkbox"/> Fax <input type="checkbox"/> Mail</p> <p>Send to:</p>
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Fax to: 602-381-8503 **OR** Email to: quotes@heartlandltc.com
Questions? Call Us at 602-381-8500 or 800-381-8504



Long Term Care Insurance Fact Finder:

Do You Have Any Personal Experiences with Long Term Care in your family? _____

Have You Started looking into Coverage Options for yourself? If So With Whom? _____

Where there any Specific Options That you Specifically Wanted to Have (Or Didn't Like)? _____

Will you be purchasing this coverage to (a.) Meet Actual Costs, (b.) Self Insure Part and Use Policy to Pay Partial Costs or (c.) Have Potential to Pay Costs and have excess cash Replace Income Stream? _____

Personal Information:

Are you Married or Have Been Living with a Partner for over 3 years? _____

Will your Spouse/Partner Also Be Applying? _____

All Health conditions – Major to Minor are added together for the final rate class and cost of coverage. Please note all diagnosed health conditions that have been treated in the past 5 years (High Blood Pressure, Depression, Diabetics, Arthritis, Osteoporosis etc.) and any major conditions going back 10-15 years (cancers, heart attacks, strokes, etc.)

Client 1:

Client 2:

Plan Design:

Where (geographically) do you expect to be when you receive care? (City, State Or Foreign Country) _____

Is there a second location also likely? (Where Children/Grandchildren live, Second Property, etc.?) _____

Most clients prefer to have care in their own home, in an Assisted Living Facility should they need to and rarely (if ever) in a Nursing Home. A plan like this is considered 'Comprehensive'. There are, however, Facility Only and Home Care Only policies that are more limited in scope and will only pay in their respective places. Are you most interested in Comprehensive, Facility Only or Home Care Only? _____

Currently the costs for uninsured care can range from \$30,000 a year to \$90,000 and beyond. Is there an amount you would like to co-pay/co-insure (i.e. 80% by the carrier, 20% by your own money, etc.) or would you rather have the policy assume all risk? _____

Policies generally have a one time deductible (elimination period) before benefits begin. Example – if your cost of care was \$180 a day and you purchased a 90 day elimination period you would need \$16,200 to cover your elimination period before coverage began. These costs will also increase over the years as costs of care/inflation increase. Would a 30 day, 60 day or 90 day be more appropriate for you? _____

Length of Contract: On average you purchase a certain pool of money like a checking account for which you can deduct funds to pay for care. Common choices are a 3 year plan, 5 year plan or Unlimited Coverage Plan. Example: A three year plan purchased at \$180 a day will start at \$197,100 of coverage per person. Also, you should review family history an current health history for long claims in your background. Pick a number of years (i.e 3 years, 4 years, 5 years, or Unlimited. _____

Would you like your coverage to be factored for Inflation so your benefits grow as costs grow? _____