



# Request for Linked-Benefit LTCi Illustration

Please fax this form to (602) 381-8503 or email to: [quotes@heartlandltc.com](mailto:quotes@heartlandltc.com)

Date: \_\_\_\_\_

**Agent Name:** \_\_\_\_\_

Would you prefer your illustration(s) be delivered by:

Email: \_\_\_\_\_

Fax: \_\_\_\_\_

UPS: \_\_\_\_\_

**Client's(s') Resident State?** \_\_\_\_\_

Are you licensed there? Yes / No

Have you completed that state's LTC training requirements?  
Yes / No

Have you completed your AML training? Yes / No

UPS shipments will be shipped via Ground Service & include the illustration(s) along with the corresponding client sales kit(s).

**Questions?**

Contact Susan Carlson at  
(602) 381-8500 or  
[Susan@heartlandltc.com](mailto:Susan@heartlandltc.com)

**Client Name:** \_\_\_\_\_ **D.O.B.:** \_\_\_\_\_

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**Tobacco User? Y / N - If Yes: Type? / How much?** \_\_\_\_\_

**Spouse/Partner Name:** \_\_\_\_\_ **D.O.B.:** \_\_\_\_\_

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**Tobacco User? Y / N - If Yes: Type? / How much?** \_\_\_\_\_

Condition or Rx Primary Insured	Date Diagnosed or Dosage of Rx	Details of Treatment(s) or Results of Rx's	Condition or Rx Spouse / Partner	Date Diagnosed or Dosage of Rx	Details of Treatment(s) or Results of Rx's

## Plan Design

### Life / LTCi

Single Premium Amount: \$ \_\_\_\_\_

Benefit Period: 4 years, \*6 years, Lifetime

Inflation: Yes / No

*\*Most Commonly Chosen*

### Annuity / LTCi

Single Premium Amount: \$ \_\_\_\_\_

Extended Benefit Period: \*36 mos., 72 mos., 108 mos., Lifetime

Inflation: Yes / No

1035 Exchange: Yes / No

Type of Money: Qualified OR Non-Qualified

*\*Most Commonly Chosen*