# Quote Request for
# LONG TERM CARE INSURANCE

E-MAIL to sdonovan@uuinc.com or FAX to 603-778-7918

**Date Requested:** _____ / _____ / __________

**Producer Information:**

Name: ______________________________ E-mail: ______________________________

Phone: ______________________________ Fax: ______________________________

Method you would like the quote returned to you: ☐ E-mail ☐ Fax ☐ Broker Pick-Up

**Client Information:**

Name: ______________________________ Date of Birth: _____ / _____ / __________ ☐ Male / ☐ Female

State of Residence: ______________________________

Health Class: ☐ Preferred ☐ Standard Height: _____' _____" Weight: __________ lbs.

Ever used tobacco products? ☐ No ☐ Yes, type: ☐ Cigarettes ☐ Cigar ☐ Pipe ☐ Chewing Tobacco

If quit, when: ______________________________

List any medical problems: ______________________________

______________________________

List any medications & dosages: ______________________________

______________________________

**Coverage Needs:**

Carrier Preference, if any? ______________________________

Plan, if known: ______________________________

Daily Benefit Amount: $ _______________ Home Care: ☐ 50% ☐ 75% ☐ 100%

Benefit Period: ☐ 2 years ☐ 4 years ☐ Lifetime ☐ Other: ______________________________

Elimination Period: ☐ 0 days ☐ 30 days ☐ 90 days ☐ Other: __________ days

Inflation: ☐ Simple ☐ Compound ☐ Cost of Living

Optional Benefits: ☐ Cost of Living ☐ Other: ______________________________

**Other Information:** ______________________________

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