United Underwriters Inc.

Quote Request for
LONG TERM CARE INSURANCE

E-MAIL to jphilibotte@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: _____

_____

_____

_____

_____