Return to - jim@uswolfe.com or Fax to 815-377-3556
Policy Number_____ Date_____/_____/_____

LTC General Purpose Request & Questionnaire

Client Name: _____ Spouse Name: _____
Client D.O.B.:_____ Spouse D.O.B.:_____

1) Client Tobacco User: **Yes No** Spouse Tobacco User: **Yes No**
A) Non-Tobacco user for at least 12 months?
Client: **Yes No** Spouse: **Yes No**

2) Client Rate Class?: **Pref. / Standard** Spouse Rate Class: **Pref. / Standard**

3) If married, is your spouse applying for coverage? **Yes No**

4) Do the insured(s) hold a valid drivers license & drive at least two times per week? **Yes No** **If "NO" who/details**: _____
_____

5) On a weekly basis, do the insured(s) work or volunteer outside of the home or participate in any volunteer activities or organizations? **Yes No**
Details:_____
_____

6) Are the insured(s) able to maintain their place of residence and perform regular daily activities without assistance? **Yes No**
If no explain:_____

7) Do the insured(s) own their own place of residence? **Yes No**

8) Insured(s) state of residence? _____ **9)** Desired effective date:_____

10) Is the plan a: **Tax Qualified Plan Non Tax Qualified Plan**

11) Circle one: **Daily Benefit or Monthly Benefit**

12) Benefit Amount $_____ Elimination Period_____ Benefit Period_____

13) <u>Riders</u>
Inflation Rider: **None 5% Simple 5% compound 5% Compound 2X**
Riders **10 Pay 20 Pay ROP Non-Forfeiture D.B. Shared Care**
Other: _____

14) Mode of payment: **Annual Semi-Annual Quarterly Monthly**

15) List all known health conditions for each insured: _____
_____
_____
_____

16) List all treatments including medications and dosages:_____
_____
_____

17) Please indicate if you would like a specific carrier: _____

Agent Name_____ Agent Number:_____
Agent Phone Number:_____ Fax Number:_____
Agent Email:_____