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LTC Quote Request

Agent Name:		Date of request:		Appointment Date:	
Phone:		Email:			
Client Information:				Spouse/Companion Information:	
Name:		Age:		Name:	
DOB: / /		Height:		DOB: / /	
State of Residence:		App Signature State:		Weight:	
Married <input type="checkbox"/>		Single <input type="checkbox"/>		Domestic Partner: <input type="checkbox"/>	
Business Owner?		If yes, Business type		If Domestic Partner, how long?	
		C- Corp <input type="checkbox"/> S-Corp <input type="checkbox"/>		Professional Corp <input type="checkbox"/> LLC/LLP <input type="checkbox"/> Self Employed <input type="checkbox"/>	
Long Term Care Benefits: Choose Benefits or Target Premium \$ _____				Asset-Based <input type="checkbox"/> Life <input type="checkbox"/> Annuity <input type="checkbox"/>	
Benefit Amount	Elimination Period	Benefit Period	Inflation Protection	Additional Riders	OR
<input type="checkbox"/> \$	<input type="checkbox"/> 30 Days	<input type="checkbox"/> 2 Year	<input type="checkbox"/> GPO	<input type="checkbox"/> Shared Care/Shared Benefit	<input type="checkbox"/> Single Premium \$ _____
<input type="checkbox"/> Daily	<input type="checkbox"/> 60 Days	<input type="checkbox"/> 3 year	<input type="checkbox"/> 5% Simple	<input type="checkbox"/> Return of Premium	<input type="checkbox"/> Monthly Benefit \$ _____
<input type="checkbox"/> Monthly	<input type="checkbox"/> 90 Days	<input type="checkbox"/> 4 Year	<input type="checkbox"/> 3% <input type="checkbox"/> 5% Compound	<input type="checkbox"/> 0-day Home Elimination Period	<input type="checkbox"/> No Inflation
<input type="checkbox"/> Cash	<input type="checkbox"/> 180 Days	<input type="checkbox"/> 5 or 6 Year	<input type="checkbox"/> None	<input type="checkbox"/> Survivorship	<input type="checkbox"/> 3% or <input type="checkbox"/> 5% Simple Inflation
	<input type="checkbox"/> 365 Days	<input type="checkbox"/> Lifetime	<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> 3% or <input type="checkbox"/> 5% Compound Inflation
Payment Options:		<input type="checkbox"/> Lifetime Pay <input type="checkbox"/> 10 Pay <input type="checkbox"/> Pay to Age 65		Partnership Plan Requested: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Underwriting Information:		Client: Preferred <input type="checkbox"/> Standard <input type="checkbox"/>		Spouse / Companion: Preferred <input type="checkbox"/> Standard <input type="checkbox"/>	
Tobacco use last 5 yrs		Yes <input type="checkbox"/> No <input type="checkbox"/> Quit Date _____		Yes <input type="checkbox"/> No <input type="checkbox"/> Quit Date _____	
Health Conditions & Diagnosis Dates					
Medications-dosage, date started, reason for taking					
Hospitalizations in last 5 yrs-Reasons & dates					