EQUITAS ADVISORS LLC
EQUITAS BROKERAGE GROUP
Making Life Happen

LONG TERM CARE QUOTE REQUEST

State: _____

Name: _____ D.O.B. _____
Height: _____Weight: _____ Health Status: _____
Taking any medications: Y or N
If yes, please provide name(s) and reason taking:
_____
_____
Any additional health concerns or major hospitalizations:
_____

Spouse: _____ D.O.B. _____
Height: _____Weight: _____ Health Status: _____
Taking any medications: Y or N
If yes, please provide name(s) and reason taking:
_____
_____
Any additional health concerns or major hospitalizations:
_____

Shared Plan: ☐ Yes ☐ No ☐ Illustrate Both

Daily Benefit: ☐ or Monthly Benefit: ☐

Elimination Period: ☐30 days ☐90 days ☐180 days

Benefit Period: ☐2 yr ☐3 yr ☐4 yr ☐6 yr ☐8 yr

Inflation: ☐None ☐Simple ☐3% Comp ☐ 5% Compound

Zero Day Home Care Elimination Period: ☐ Yes ☐ No

Notes: _____
_____

Broker: _____ Agency: _____
Phone: _____ Fax: _____
Email: _____