KAFL
INSURANCE RESOURCES

Long Term Care Quote Request Form

Client's Name: _____ Gender: M___F___ Date of Birth: __/__/____

Spouse: _____ Gender: M___F___ Date of Birth: __/__/____

State Residence: _____

Benefit Amount $_____ Do you want a partnership quote? Y___N____

Please Circle Choice Below

Benefit Period: 2yr _____ 3yr ____ 4yr____ 5yr ____

Shared Benefit: Y____ N_____ _____

Elimination Period: 30 days ____ 60 days ____ 90 days ____ 180 days ____

Inflation Rider: 3% compound/simple _____ 5% compound/simple _____

Home Care Percentage: 50%____ 75% ____ 100% ____

Optional Riders:_____

Pre-Qualification Questions

Client Spouse/Partner

1. Do you currently require human assistance or supervision in order to perform any of the following activities: bathing, dressing, eating, getting out of bed/chair, walking, or toileting?
2. Have you had Cancer?
3. Diabetes: If yes: Type: _____
4. Do you have any scheduled or recommended treatments or surgeries? (List below)
5. Have you ever been diagnosed or treated by a health care professional for any major medical condition(s)? Please list below.
6. Are you taking Rx medications? If yes, please list all medications below, along with each condition that was prescribed for and dosage amounts.

Details to "YES" answers above and ALL medications taken

Client	Spouse

Return to:
KAFL Insurance Resources:
800 Linden Avenue
Rochester, NY 14625
fax: (585) 271-5050 or e-mail
marketing@kafl.com

Agent: _____

Phone: _____

Print

Clear Form