

## Long Term Care Quote Request

Agent: \_\_\_\_\_  
Agent Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Email address: \_\_\_\_\_  
Return Quote By: Fax: \_\_\_ Phone: \_\_\_ Email \_\_\_ Mail: \_\_\_

Prospect Name: \_\_\_\_\_  
Sex: M or F      DOB: \_\_\_\_\_

State where application will be signed: \_\_\_\_\_

1. Tobacco Use: Never \_\_\_ Cigarette \_\_\_ Cigar \_\_\_ Chewing Tobacco \_\_\_ Quit \_\_\_\_\_
2. Partner/Spouse: \_\_\_\_\_
3. Employer Paid?: \_\_\_\_\_
4. Date Last seen a Doctor \_\_\_\_\_ Reason: \_\_\_\_\_
5. Medication taken currently: \_\_\_\_\_
6. Daily Usage: \_\_\_\_\_
9. Aviation/Avocation: \_\_\_\_\_
10. Any other information we need to know about client's Occupation or duties:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Benefit Period Mode: Daily/ Monthly      Elimination Period: 30 60 90 180 360 Days

Benefit Period: \_\_\_ years or Life time      Benefit Amount: \_\_\_\_\_

Riders: \_\_\_\_\_

Other comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date requested: \_\_\_\_\_      Date returned: \_\_\_\_\_

Requested by: \_\_\_\_\_

Prepared By: \_\_\_\_\_

**Please Fax your quote request to GAIN**  
**Fax: 512-251-1912    Toll Free: 1-877-847-6426**  
**Or call: 1-800-847-6426**