America's Long-Term Care Insurance Experts℠

MyTopAgents.com
Larry Whiteside
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AGENT NAME _____ **E-Mail** _____ **Phone** _____

CLIENT #1		CLIENT #2	
NAME:		**NAME:**	
DATE OF BIRTH:		**DATE OF BIRTH:**	
HEIGHT:	**WEIGHT:**	**HEIGHT:**	**WEIGHT:**
Medications/Dosages/Reason for taking:		**Medications/Dosages/Reason for taking:**	
Tobacco Use Last 12 months? Yes___ No___		**Tobacco Use Last 12 months? Yes____ No____**	

INDICATE IF YOU HAVE BEEN MEDICALLY DIAGNOSED OR TREATED FOR ANY OF THE CONDITIONS BELOW:

	Yes	No		Yes	No
Abnormal Blood Pressure	Yes	No	Abnormal Blood Pressure	Yes	No
Diabetes	Yes	No	Diabetes	Yes	No
Heart or Circulatory Disorder	Yes	No	Heart or Circulatory Disorder	Yes	No
Cancer	Yes	No	Cancer	Yes	No
Chronic Respiratory Disorder	Yes	No	Chronic Respiratory Disorder	Yes	No
Stroke or TIA	Yes	No	Stroke or TIA	Yes	No
Falling or Unstable Gait	Yes	No	Falling or Unstable Gait	Yes	No
Dizziness or Fainting	Yes	No	Dizziness or Fainting	Yes	No
Confusion or Memory Loss	Yes	No	Confusion or Memory Loss	Yes	No
Weakness or Fatigue	Yes	No	Weakness or Fatigue	Yes	No
Bladder or Bowel Control	Yes	No	Bladder or Bowel Control	Yes	No
Neurological Disorder	Yes	No	Neurological Disorder	Yes	No
Receiving physical therapy	Yes	No	Receiving physical therapy	Yes	No
Scheduled treatment or surgery	Yes	No	Scheduled treatment or surgery	Yes	No

REQUESTED BENEFIT DESIGN: (Choose One)

Daily Benefit:_____ **Benefit Period:**_____

Inflation Protection: □None □ 5% Simple □5% Compound

Elimination Period: □0 □30 □60 □90 □180

Additional Riders: □Shared Care □Survivorship Waiver

□Dual Waiver of Premium □Restoration of Benefits

□Other: _____

_____

_____

□ **Quick Quote:**

- **5 Year Benefit Period**
- **Daily Benefit Equivalent to Cost of Care**
- **60 Day Elimination Period**
- **3 Company Premium Spreadsheet**
- **Detailed quote w/multiple options from company with lowest premium**