

## Quote Request for LONG TERM CARE INSURANCE

E-MAIL to quotes@bsibroker.com or FAX to 301-540-8787

Producer information:  Name:		Date Requested:/	
Phone: Fax:	Producer Information:		
Method you would like the quote returned to you:	Name:	E-mail:	
Client Information:  Name: Date of Birth:// Male / □ Ferestate of Residence:  Health Class: □ Preferred □ Standard Height:/ " Weight: Ibs.  Ever used tobacco products? □ No □ Yes, type: □ Cigarettes □ Cigar □ Pipe □ Chewing Tobacco  If quit, when: List any medical problems:  List any medications & dosages:  Coverage Needs:  Carrier Preference, if any?  Plan, if known: Home Care: □ 50% □ 75% □ 100%  Benefit Period: □ 2 years □ 4 years □ Lifetime □ Other: days  Inflation: □ Simple □ Compound □ Cost of Living	Phone:	Fax:	
Name: Date of Birth://	Method you would like the quote returned to you: □ E-mail □ Fax □ Broker Pick-Up		
Name: Date of Birth:// Male / □ Ferestate of Residence:			
State of Residence:  Health Class:	Client Information:		
Health Class:   Preferred   Standard   Height:'" Weight:  lbs.  Ever used tobacco products?   No   Yes, type:   Cigarettes   Cigar   Pipe   Chewing Tobacco  If quit, when:  List any medical problems:  List any medications & dosages:  Coverage Needs:  Carrier Preference, if any?  Plan, if known:  Daily Benefit Amount: \$ Home Care:   50%   75%   100%  Benefit Period:   2 years   4 years   Lifetime   Other: days  Inflation:   Simple   Compound   Cost of Living	Name:	Date of Birth:/	
Ever used tobacco products?   No   Yes, type:   Cigarettes   Cigar   Pipe   Chewing Tobacco  If quit, when:  List any medical problems:  List any medications & dosages:  Coverage Needs:  Carrier Preference, if any?  Plan, if known:  Daily Benefit Amount: \$ Home Care:   50%   75%   100%  Benefit Period:   2 years   4 years   Lifetime   Other: days  Inflation:   Simple   Compound   Cost of Living	State of Residence:		
If quit, when:     List any medical problems:     List any medications & dosages:     Coverage Needs:     Carrier Preference, if any?     Plan, if known:     Daily Benefit Amount: \$   Home Care:   50%   75%   100%     Benefit Period:   2 years   4 years   Lifetime   Other:     Elimination Period:   0 days   30 days   90 days   Other:   days     Inflation:   Simple   Compound   Cost of Living	Health Class:   Preferred   Standard	Height:'" Weight:lbs.	
List any medical problems:	Ever used tobacco products?   No Yes, type:  Cigare	ettes 🗆 Cigar 🗆 Pipe 🗆 Chewing Tobacco	
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Coverage Needs:  Carrier Preference, if any?  Plan, if known:  Daily Benefit Amount: \$ Home Care:   50%   75%   100%  Benefit Period:   2 years   4 years   Lifetime   Other: days  Elimination Period:   0 days   30 days   90 days   Other: days  Inflation:   Simple   Compound   Cost of Living	List any medical problems:		
Coverage Needs:  Carrier Preference, if any?  Plan, if known:  Daily Benefit Amount: \$ Home Care:   50%   75%   100%  Benefit Period:   2 years   4 years   Lifetime   Other: days  Elimination Period:   0 days   30 days   90 days   Other: days  Inflation:   Simple   Compound   Cost of Living			
Coverage Needs:  Carrier Preference, if any?  Plan, if known:  Daily Benefit Amount: \$ Home Care: 50% 75% 100%  Benefit Period: 2 years 4 years Lifetime Other:  Elimination Period: 0 days 90 days Other: days  Inflation: Simple Compound Cost of Living	List any medications & dosages:		
Carrier Preference, if any? Plan, if known: Home Care:   50%   75%   100% Benefit Amount: \$ Other: days   100%   2 years   4 years   Lifetime   Other: days   100%			
Carrier Preference, if any? Plan, if known: Home Care:   50%   75%   100% Benefit Amount: \$ Other: days   100%   2 years   4 years   Lifetime   Other: days   100%			
Plan, if known:  Daily Benefit Amount: \$ Home Care:   50%   75%   100%  Benefit Period:   2 years   4 years   Lifetime   Other: days  Elimination Period:   0 days   30 days   90 days   Other: days  Inflation:   Simple   Compound   Cost of Living	Coverage Needs:		
Daily Benefit Amount: \$ Home Care:   50%   75%   100%  Benefit Period:   2 years   4 years   Lifetime   Other: days  Elimination Period:   0 days   30 days   90 days   Other: days  Inflation:   Simple   Compound   Cost of Living	Carrier Preference, if any?		
Benefit Period: 2 years 4 years	Plan, if known:		
Elimination Period:	Daily Benefit Amount: \$	Home Care: □ 50% □ 75% □ 100%	
Inflation:   Simple Compound Cost of Living	Benefit Period:   2 years   4 years   Lifetime   O	ther:	
	Elimination Period: 🗆 0 days 🗆 30 days 🗆 90 days 🗆	Other: days	
Optional Benefits:   Cost of Living   Other:	Inflation:   Simple   Compound   Cost of Living		
	Optional Benefits:   Cost of Living   Other:		
Other Information:	Other Information:		