Individual Long Term Care Insurance Request for Proposal

Please fill out the following information entirely. If applicable, please provide your spouse's information on the second page.

KTB Associate: _____

Producer Name: _____

Phone: _____

Facsimile: _____

Email Address: _____

Client Name: _____

State of Residence: _____

Date of Birth: _____

Height: _____

Weight: _____

Tobacco Use:

Yes No

Health History:
(Medications, Treatments, Hospital Stays, Include Dates and Diagnosis)

_____

_____

_____

_____

Special Requests:

_____

_____

_____

_____

Plan Requested:

Benefit Period
(# of years) _____

Elimination Period
(# of days) _____

Nursing Home Benefit:
($/month) _____

Home Health Care:

100% 50% of Nursing Home Benefit Amount

Inflation Protection:

None Simple Compound

Spouse Information

Client Name: _____

State of Residence: _____

Date of Birth: _____

Height: _____

Weight: _____

Tobacco Use:

Yes No

Health History:
(Medications, Treatments, Hospital Stays, Include Dates and Diagnosis)

_____

_____

_____

_____

Special Requests:

_____

_____

_____

_____

Plan Requested:

Benefit Period
(# of years) _____
Elimination Period
(# of days) _____
Nursing Home Benefit:
($/month) _____

Home Health Care:
100% 50% of Nursing Home Benefit Amount

Inflation Protection:

None Simple Compound

Tax Qualification:

Tax Qualified Non Tax Qualified Both