

LTCl Quote Request Form

Date: ____/____/____

Please print legibly.

Agent Information

Name: _____
Date Proposal Needed: _____ Email: _____
Phone Number: () _____ Fax Number: () _____
Company Name: _____
Address: _____ Suite/Floor: _____
City: _____ State: _____ Zip Code: _____

Please designate if the above address is a residential or commercial address.

Would you like your quote EMAILED FAXED or MAILED to you? Please see note at bottom of form*.

Supplies Requested with Quote

Send Supplies? Yes No Are You Appointed with Level Four and the Carrier? Yes No
Carriers: _____ States: _____
 Brochures Software Appointment Papers Medicare Guides Apps
 Specimen Policies Shoppers Guides Underwriting/Rate Guides Other _____

Some carriers require pre-appointment before applications can be taken. Please make sure you are appointed with Level Four before taking an application.

Client Information

Client Name: _____ DOB: ____/____/____ Age: _____
Marital Status: _____ Is the Spouse Applying? Yes No
If "YES" Spouse's Name: _____ DOB: ____/____/____ Age: _____
Client's Resident State _____ State where application will be signed _____
If an application is signed in a state other than the resident state, a valid reason must be given.

Policy Options

Carriers with whom you are appointed through Level Four: _____
Carrier quote(s) requested: _____

Standard Plan Options

Nursing Home Daily Benefit: \$ _____ Nursing Home Benefit Duration: _____ Years.
HHC Daily Benefit Amount: \$ _____ Home Health Care Benefit Duration: _____ Years.
Elimination Period: _____ Days

Inflation Protection Option (please circle one of the following): Simple Compound CPI None
In most cases the nursing home and home health care benefit durations will be the same. In most cases the home health care benefit amount will be either 50%, 75%, 80% or 100% of the nursing home benefit depending on the carrier.

Notes:

**Level Four will only quote a standard rate unless a detailed medical history is provided along with a quote request form. Give us a call and we will fax you a medical history form.*

Fax to Level Four at (214) 969-1919. Call (214) 969-1888 with any questions.

LTCl Medical History Form

Date: ____/____/____

Please print legibly.

Agent Information

Name: _____
Date Proposal Needed: _____ Email: _____
Phone Number (_____) _____ Fax Number: (_____) _____
Company Name: _____
Address: _____ Suite/Floor: _____
City: _____ State: _____ Zip Code: _____

Client Information

Client Name: _____ DOB: ____/____/____ Age: ____
Height: _____ Weight: _____
Smokes Cigarettes? Yes No Smokes Cigars? Yes No
If you have quit smoking how long has it been? _____

Hospitalizations in the Past 10 Years

(1) Dates: ____/____/____ to ____/____/____
Cause: _____ Result: _____
(2) Dates: ____/____/____ to ____/____/____
Cause: _____ Result: _____
(3) Dates: ____/____/____ to ____/____/____
Cause: _____ Result: _____

Medications Currently Taken

Medication: _____ Taken for: _____ Dosage: _____ x/Day: _____
Medication: _____ Taken for: _____ Dosage: _____ x/Day: _____
Medication: _____ Taken for: _____ Dosage: _____ x/Day: _____
Medication: _____ Taken for: _____ Dosage: _____ x/Day: _____
Medication: _____ Taken for: _____ Dosage: _____ x/Day: _____

Medical Conditions Treated in the Past 10 Years

Condition: _____ Date: ____/____/____
Condition: _____ Date: ____/____/____
Condition: _____ Date: ____/____/____
Condition: _____ Date: ____/____/____

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