Life's Solutions @ GBL

12006 Ridgemont Drive Urbandale, IA 50323 (800) 640-7382 (515) 453-8207 Fax: (515) 222-5342

Please Provide All Information Below For An Accurate Quote

Long Term Care Quote Request Form

AGENT CONTACT INFORMATION:

Name: Benefit Advocates Work#: 515-254-1900

Email Address: trent@benefitadvocatesia.com Fax#: 319-409-8234

INSURED INFORMATION:

Name: _____ Date of Birth: _____

Gender: ____ Male ____ Female Weight: _____ Height: _____ State: _____

Tobacco User?: ____ Yes ____ No What type of Tobacco Use?: _____

How Often?: _____ Married: ____ Yes ____ No Is Spouse applying for Coverage?: ___ Yes ____ No

Any known Health Conditions (include onset dates, treatment, and medications): _____

Please provide the following Spouse Information:

Name: _____ Date of Birth: _____

Gender: ____ Male ____ Female Weight: _____ Height: _____ State: _____

Tobacco User?: ____ Yes ____ No What type of Tobacco Use?: _____

How Often?: _____ Married: ____ Yes ____ No Is Spouse applying for Coverage?: ___ Yes ____ No

Any known Health Conditions (include onset dates, treatment, and medications): _____

Client Profile

Does your client have or has been medically diagnosed with the following: ☐ Acquired Immune Deficiency Syndrome (AIDS) ☐ HIV Positive ☐ Alzheimer's Disease ☐ ALS (Lou Gehrig's Disease) ☐ Down's Syndrome ☐ Cerebral Palsy ☐ Chronic Memory Loss ☐ Senility/Dementia ☐ Muscular Dystrophy ☐ Huntington's Chorea ☐ Psychosis/Schizophrenia ☐ Organic Brain Syndrome

Does your client currently need the following: ☐ Walker ☐ Wheelchair ☐ Oxygen ☐ Kidney Dialysis

Does your client currently need assistance or supervision in performing the following: ☐ Moving in and out of bed or chair ☐ Eating ☐ Bathing ☐ Dressing ☐ Using the Toilet

Within the past **five (5) years** has your client received medical advice or treatment, taken medications for, been diagnosed, confined to a convalescent care facility, hospital, or nursing facility, or visited a professional for any of the following conditions (if YES, circle all that apply):

YES NO

☐ ☐ Paralysis, Stroke, Transient Ischemic Attack (TIA), Hodgkin's Disease, Leukemia, Lymphoma, Cancer, Heart Surgery, Angioplasty, Heart Attack, High Blood Pressure, Congestive Heart Failure, Disabling Back/Spine

☐ ☐ Emphysema, Shortness of Breath, Fainting Spells, Blacking Out, Injury Due to Falls/Imbalance

☐ ☐ Brain Disorder, Mental Illness, Depression, Alcoholism, Drug Addiction

☐ ☐ Epilepsy, Seizures, Convulsions , Tremor, Diabetes, Skin Ulcers

☐ ☐ Multiple Sclerosis, Osteoporosis, Arthritis, Other conditions causing crippling or limited motion

Details for "YES" answers to any part of questions 1, 2, and 3:

_____

_____

_____

_____

During the past **three (3) years**, have you:

YES NO

☐ ☐ Been medically advised for surgery which has not been performed or had therapy?

☐ ☐ Consulted with or been treated by a health professional for reasons not previously stated? (excluding eye doctors, podiatrists, dentists and chiropractors)

☐ ☐ Received home care, used an adult day care facility, been medically advised to enter a nursing home, or confined to a hospital/other health care facility?

Daily Benefit Amount? ($100 - $500) _____ (National Average is $150 for Nursing Home)

Elimination Period (Days): ☐ 0 ☐ 30 ☐ 90

Benefit Period: ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Lifetime

Home Health Care?: ☐ Yes ☐ No

Automatic Benefit Increase Rider: ☐ 3% ☐ 5% ☐ Simple ☐ Compound

Return of Premium: ☐ **Yes** ☐ **No** **Shared Plan:** ☐ **Yes** ☐ **No**

Special Instructions: _____

Please Submit Request to:

Jennifer Sprague: jsprague@grpbenltd.com | (515) 330-3072