LONG-TERM CARE PROPOSAL REQUEST

CLIENT 1 PROFILE:

Name: _____ Gender: ____ DOB: _____ State: _____

Height: _____Weight: _____ Smoker (Y/N): ____ If Y, Type: _____ Date of Last Use: _____

Current Medication(s) – Please Include Name and Reason(s) for Use: _____

_____

_____

Medical History (Hospitalizations, Conditions, Diseases, Health Concerns - Include Date of Diagnosis):

_____

_____

Insurance Declines (If Any - Include Date, Reason and Carrier): _____

CLIENT 2 (SPOUSE/PARTNER) PROFILE:

Name: _____ Gender: _____ DOB: _____ State: _____

Height: _____Weight: _____ Smoker (Y/N): ___ If Y, Type: _____ Date of Last Use: _____

Current Medication(s) – Please Include Name and Reason(s) for Use: _____

_____

_____

Medical History (Hospitalizations, Conditions, Diseases, Health Concerns - Include Date of Diagnosis):

_____

_____

Insurance Declines (If Any - Include Date, Reason and Carrier): _____

ADDITIONAL NOTES: _____

_____

_____

COVERAGE OPTIONS:

Benefit Amount(s): _____

BENEFIT PERIOD:

- ☐ 2 Years
- ☐ 3 Years
- ☐ 4 Years
- ☐ 5 Years

ELIMINATION PERIOD:

- ☐ 30 Days
- ☐ 60 Days
- ☐ 90 Days
- ☐ 180 Days

INFLATION OPTION:

- ☐ None
- ☐ 3% Compound
- ☐ 5% Compound

RIDERS:

- ☐ Zero Day Home Care Elimination Period
- ☐ Shared Care (Couples Only)
- ☐ Joint Waiver of Premium

AGENT INFORMATION:

Name: _____ Agency: _____

Contact #: _____ Email: _____

SUBMIT THE COMPLETED FORM VIA EMAIL
individuallife@savoyassociates.com

QUESTIONS? ASK OUR INDIVIDUAL LIFE TEAM
516.390.2710