LONG TERM CARE INSURANCE

Quote Request

CPS INSURANCE SERVICES

COMPLETE AND EMAIL TO PJ@CPSGSB.COM

AGENT NAME	DATE OF LTC CE COMPLETION	DATE NEEDED
PHONE NUMBER	EMAIL	

CLIENT NAME / STATE OF RESIDENCE	SPOUSE / PARTNER NAME / STATE OF RESIDENCE
DATE OF BIRTH / HEIGHT / WEIGHT MARITAL STATUS S / M / Domestic Partner	DATE OF BIRTH / HEIGHT / WEIGHT
MEDICAL CONDITION OR HOSPITALIZATION (Last 10 Years) SMOKER ☐ Yes ☐ No	**MEDICAL CONDITION OR HOSPITALIZATION** (Last 10 Years) SMOKER ☐ Yes ☐ No
MEDICATIONS	MEDICATIONS

PLAN DESIGN OR TARGETED PREMIUM ANNUALLY$______________

Benefit Amount $ ___________(Typically $4500) Benefit
Duration _________________Years (Typically 3 years)
Elimination Period _________ Days (Typically 90 days)

INFLATION

☐ CPS Recommendation ☐ 3% Comp (Typically used) ☐ None or GPO ☐ 5% Compound

RIDERS ☐ Shared Care
☐ Zero day elimination for Home Care