Long Term Care Quote Request

Email to quotes@gain1776.com or Fax request to 512-251-1912 / 877-847-6426

Agent Name: _____ Date: _____

Return Quote by: *0* Email: _____

0 Fax: _____ *0* Phone: _____

0 Mail: _____

_____

0 Rush Quote Request

Client Name: _____

Sex: *0* Male *0* Female DOB: _____ or Age: _____

State where application will be signed in: _____

Premium Mode: *0* Annual *0* Semiannual *0* Quarterly *0* Monthly/PAC

Tobacco Use: *0* Never *0* Cigarettes *0* Cigar *0* Chewing Tobacco *0* Other: _____

If applicable: Quit Date: _____ Frequency: _____

0 Preferred Health *0* See medical conditions below to determine

Marital Status: *0* Single *0* Married *0* Cohabiting with someone If they are also applying, provide:

Name: _____ Sex: *0* Male *0* Female DOB: _____ or Age: _____

Benefit: Period: *0* # of Yrs: _____ or *0* Lifetime

Mode: *0* Daily or *0* Monthly Amount: _____

Riders: *0* Nonforfeiture *0* ROP *0* Home Health Care *0* Other: _____

Inflation: *0* None *0* 3% *0* 3% Compound *0* 5% *0* 5% Compound *0* Other: _____

Elimination Period: *0* 30 *0* 60 *0* 90 *0* 180 *0* 360 Days

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Medication(s): For additional details, see Comments below.

Name of Medication	Dose	Frequency	Reason/Disease	Onset Age

Other Medical Condition(s): For additional details, see Comments below.

Disease/Disorder	Onset Age	Treatment	Recent Test/Result/Episode

Last seen a doctor: Date: _____ Reason: _____ Results: _____

Occupation/Duties: _____

Avocations/Hobbies: _____

Comments: _____

_____

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