LTC/Linked Benefits Illustration Questionnaire

Agent Name: _____ Date Needed: _____

Agent Phone: _____ Agent Email: _____

Primary Insured Name: _____

☐ Check if Proposed Insured is married (discount may apply). Complete second page if spouse or co-applicant intends to be covered by a joint or individual policy with Proposed Insured.

Date of Birth: _____ Sex: _____ Height: _____ Weight: _____

Last Nicotine Use: _____ State of Residence: _____ State Where App Will Be signed: _____

Illustration Design Information:

Monthly Benefit Desired: $_____	**OR** (See in the chart below for more options)

Single premium: $_____ **OR** **Annual premium: $**_____ ☐ 10-Pay OR Desired number of years? _____	**Benefit Period Desired?** ☐ 4 years ☐ 5 years ☐ 6 years ☐ Lifetime
Premium coming from: ☐ Non-Qualified Annuity ☐ Employer Pay ☐ Cash/CD/Savings ☐ Qualified Funds ☐ HSA Reimbursement ☐ 1035 Exchange of Existing Insurance ☐ Earned Income	**Inflation of benefits to keep pace with costs?** ☐ Yes ☐ No **Return of Premium?** ☐ Yes ☐ No

List details of any medical conditions in the past 10 years * (Complete as much as known)

Especially High Blood Pressure, Heart Attack, Angina, Angioplasty, Atrial Fibrillation, Stroke/TIA, Arthritis (all types), Diabetes, Osteoporosis, PSA, Cancer, Fibromyalgia, Anxiety/Depression, Surgeries or Hospital Stays, Previous LTCI Declines, Steroid Injections

Medical Condition:	Prescription Medications:	Dose & Frequency:

* Auto Decline Conditions: ADL Deficit(s), AIDS, Alcoholism (4 or more drinks a day), ALS (Lou Gehrig's Disease), Alzheimer's Disease, Congestive Heart Failure, Cystic Fibrosis, Equipment Use (4 pronged cane, walker or wheelchair), HIV, Multiple Sclerosis, Muscular Dystrophy, Multiple Myeloma, Oxygen Use, Paralysis/Paraplegia/Quadriplegia, Parkinson's Disease, Transplants.

Fax completed form to SBG: 763-404-8389 or email to: dhull@sbgroupinc.com

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LTC/Linked Benefits Illustration Questionnaire

Secondary Proposed Insured: _____

Date of Birth: _____ Sex: _____ Height: _____ Weight: _____

Last Nicotine Use: _____ State of Residence: _____ State Where App Will Be signed: _____

Illustration Design Information:

Monthly Benefit Desired: $_____	**OR** (See in the chart below for more options)

Single premium: $_____ **OR** **Annual premium: $**_____ ☐ 10-Pay OR Desired number of years? _____	**Benefit Period Desired?** ☐ 4 years ☐ 5 years ☐ 6 years ☐ Lifetime
Premium coming from: ☐ Non-Qualified Annuity ☐ Employer Pay ☐ Cash/CD/Savings ☐ Qualified Funds ☐ HSA Reimbursement ☐ 1035 Exchange of Existing Insurance ☐ Earned Income	**Inflation of benefits to keep pace with costs?** ☐ Yes ☐ No **Return of Premium?** ☐ Yes ☐ No

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Especially High Blood Pressure, Heart Attack, Angina, Angioplasty, Atrial Fibrillation, Stroke/TIA, Arthritis (all types), Diabetes, Osteoporosis, PSA, Cancer, Fibromyalgia, Anxiety/Depression, Surgeries or Hospital Stays, Previous LTCI Declines, Steroid Injections

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