MVP Financial Services, Inc.

Long-Term Care/Chronic Illness Quote Request

Date: _____

Advisor Name: _____ **email:** _____ **phone:** _____

Health Licensed in state of ____ **Long-Term Care Training/Education Expires:** _____

Purpose of Coverage: _____

Applicant Name: _____ Gender: _____ DOB: _____ Resident State: _____

If ever filed for bankruptcy, provide date(S): _____ Previously declined for LTC insurance? _____

Currently receiving disability benefits? _____ If yes, provide type/reason: _____

Quoting companion's name: _____ Relationship to applicant: _____
(please complete and submit a separate quote request form for spouse, family member or partner)

Within the last 5 years, has applicant received medical advice, diagnosis, treatment or consulted with a medical professional for any of the following conditions:

Personal Health Information (Answer Yes or No and provide dates/details for Yes answers)			
Tobacco/Nicotine Use: _____	Type Used: _____	How Often: _____	Date Last Used: _____
Height: _____ ft _____ in	Weight: _____ lbs	Weight Change: _____	Reason: _____
Diabetic: _____	Type: _____	Age Onset: _____	Details: _____
Sleep Study: _____	Apnea/Respiratory: _____	C-pap? _____	Details: _____
Hypertension: _____	Date Diagnosed: _____	Last Reading: _____	Reading Date: _____
Cancer: _____	Type: _____	Location: _____	Last Treatment: _____
Drug/Alcohol Abuse: _____	Type: _____	Amount: _____	Treatment Dates: _____
Cane/Walker: _____	Crutches: _____	Wheelchair: _____	When: _____
Handicap Parking Permit?	☐ Yes ☐ No	Any Hospitalizations?	☐ Yes ☐ No
Heart Disease?	☐ Yes ☐ No	Any Physical Therapy?	☐ Yes ☐ No
Carotid Artery Disease?	☐ Yes ☐ No	Transient Ischemia Attack?	☐ Yes ☐ No
Peripheral Vascular Disease?	☐ Yes ☐ No	Stroke/CVA?	☐ Yes ☐ No
Blood Clots/Embolism?	☐ Yes ☐ No	Alzheimer's/Dementia?	☐ Yes ☐ No
Depression/Mental Illness?	☐ Yes ☐ No	Memory Loss/Forgetful?	☐ Yes ☐ No
Chronic Fatigue/Fibromyalgia	☐ Yes ☐ No	Kidney Disease?	☐ Yes ☐ No
Crohn's/Colitis/Gastric Bypass	☐ Yes ☐ No	Liver Disorders?	☐ Yes ☐ No
Back/Spine Disorders?	☐ Yes ☐ No	Arthritis?	☐ Yes ☐ No
Osteoporosis/Fractures?	☐ Yes ☐ No	Seizure Disorders?	☐ Yes ☐ No
Visual Impairments/Loss?	☐ Yes ☐ No		
Any Medications: _____	Rx Name: _____	Dosage: _____	Date Prescribed: _____
	Rx Name: _____	Dosage: _____	Date Prescribed: _____
	Rx Name: _____	Dosage: _____	Date Prescribed: _____
Additional Medical/Health Information for context and/or not listed above:			

Case Design: ☐ **Traditional LTC** ☐ **LTC/CI Life Hybrid** **Life Death Benefit Amount: $**_____

Specify LTC Benefit Amount or write MAX: $_____ ☐ Daily or ☐ Monthly Home Care: _____%

Elimination Period Requested: _____ Benefit Period Requested: _____

Options Requested: ☐ Partial/Residual ☐ Cost of Living ☐ Future Purchase Rider: $_____

☐ Retirement Plan Deferral: $_____ ☐ Automatic Increase: _____

Other Requests (include riders, premium paying years, etc): _____