M. WILLIAMSON INSURANCE SERVICES
LIFE INSURANCE | DISABILITY INSURANCE | LONG-TERM CARE INSURANCE

For Office Use Only
Date: ______
Carrier: ______
Rep: ______

T: 631-730-8262
F: 866-275-7847

mbwinsurance.com

72 Blueberry Ridge Drive
Holtsville, NY 11742

Long-Term Care Quote Request

Producer Name		Phone Number	
Firm		Fax Number	
Email Address		Quote needed by	/ /
Street, City, State, Zip		Quote needs to be	☐ Faxed ☐ Mailed ☐ Emailed

Client Information

☐ **Please check box if married, but spouse is not applying for coverage.**

	Client	**Spouse**
Client Name		
Date of Birth		
State of Residence		
Risk Class – will assume standard if not indicated	☐ Preferred ☐ Standard (not available with all carriers)	☐ Preferred ☐ Standard (not available with all carriers)
	☐ Nonsmoker ☐ Smoker	☐ Nonsmoker ☐ Smoker
Prescriptions and Dosage		
Medical Conditions or recent hospitalization *If yes, please list details*		

Client(s) annual premium budget: $ ________ Date quote is being presented to client: ________

Plan Design

*(Please note average daily cost of **private** nursing home for 2014: Washington $280; Oregon $265; Missouri $164; Hawaii $370; Alaska $660; Idaho $233; California $285; Montana $216; Utah $200; Texas $180; Arizona $233; New Mexico $227)*

	Client	Spouse
Daily or Monthly Benefit Amount	**$**	**$**
Waiting Period*	☐ 30 day ☐ 60 day ☐ 90 day ☐ 100 day ☐ 180 day ☐ 365 day	☐ 30 day ☐ 60 day ☐ 90 day ☐ 100 day ☐ 180 day ☐ 365 day
Benefit Period*	☐ 2 year ☐ 3 year ☐ 4 year ☐ 5 year ☐ 6 year ☐ Longest available	☐ 2 year ☐ 3 year ☐ 4 year ☐ 5 year ☐ 6 year ☐ Longest available
Inflation Protection	☐ 3% Compound ☐ 5% Compound ☐ 5% Simple ☐ None	Zero Day Elimination Period for Home Care
Shared Care Option	☐ Yes ☐ No	☐ Yes ☐ No

**Exact waiting period and benefit period varies by carrier*

Quote Received

Please email or fax to:
M. Williamson Insurance – LTC Department
illustrations@mbwinsurance.com or 866.275.7847 fax

10172016

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Phone: 631-730-8262
www.mbwinsurance.com

Complete this Long-Term Care form and fax back to 866-275-7847

1. Applicant's name: ______________________ Date: ____________

   Date of birth ____________ Gender: ____________

   State of residence: ____________ Height: ____________ Weight: ____________

2. Has the applicant used tobacco products in the last 12 months? ☐ Yes ☐ No
3. Has the applicant previously applied for LTC and been declined, postponed or rated? ☐ Yes ☐ No

   If yes, please provide detail: ______________________

4. Within the last five years, have you received medical advice, diagnosis or treatment, or consulted with a member of the medical profession for any of the following conditions (check box and circle conditions):

Condition	
Circulatory Disorders: Aneurysm, Cardiomyopathy, Carotid Artery Disease, Congestive Heart Failure, Coronary Artery Disease, Embolisms, Heart Arrhythmias, High Blood Pressure, Peripheral Vascular Disease, Stroke, Transient Ischemic Attack, Valvular Disease	☐ Yes ☐ No
Endocrine and Pituitary Disorders: Diabetes, Pancreatitis	☐ Yes ☐ No
Cancers: Leukemia, Lymphoma, Melanoma, Sarcomas, Squamous Cell, Tumors	☐ Yes ☐ No
Genitourinary Disorders: Bladder Disorders, Incontinence, Kidney Failure, Prostate Disorders, Renal Insufficiency	☐ Yes ☐ No
Gastrointestinal Disorders: Cirrhosis, Crohn's Disease, Hepatitis, Liver Disorders, Ulcerative Colitis	☐ Yes ☐ No
Neurological Disorders: Anxiety, Chronic Fatigue Syndrome, Depression, Mental Illness, Neuropathy, Seizures, Tremors	☐ Yes ☐ No
Blood Disorders: Anemia, Hemochromatosis, Polycythemia Vera, Thrombocytopenia	☐ Yes ☐ No
Musculoskeletal Disorders: Arthritis, Degenerative Joint Disease, Fibromyalgia, Fractures, Lupus, Osteoarthritis, Osteopenia, Osteoporosis, Paralysis, Polymyalgia Rheumatica, Rheumatoid Arthritis, Scoliosis, Spinal Stenosis	☐ Yes ☐ No
Respiratory Disorders: Asbestosis, Asthma, Bronchiectasis, Bronchitis, Chronic Obstructive Pulmonary Disease, Emphysema, Sarcoidosis, Sleep Apnea	☐ Yes ☐ No
Eye & Ear Disorders: Glaucoma, Macular Degeneration, Meniere's/Vertigo, Retinitis Pigmentosa	☐ Yes ☐ No
Substance Abuse: Alcoholism, Drug dependency, Illicit drug use	☐ Yes ☐ No

5. Does the applicant currently use any assistive or mechanical devices? ☐ Yes ☐ No
6. Has the applicant ever received home health care, been confined to a nursing home, or rehabilitation center? ☐ Yes ☐ No
7. Does the applicant require human assistance or supervision in performing any of your activities of daily living (bathing, dressing, transferring, toileting, continence, eating)? ☐ Yes ☐ No
8. Has the applicant had a complete exam within the past 18 months? ☐ Yes ☐ No
9. Is the applicant currently receiving disability benefits? ☐ Yes ☐ No

   9a. If yes, ☐ Group or Individual? % Income Replacement: ________ % ☐ Social Security?: ________

10. Does the applicant see any specialists? If so, for what reason? ☐ Yes ☐ No
11. Are you currently receiving physical therapy or have you been advised to start? If so, for what reason? ☐ Yes ☐ No
12. Does the applicant have any pending surgeries, tests or treatments? If yes, explain: ☐ Yes ☐ No

DETAILS TO QUESTIONS 3-6:

Q# _____ Diagnosis ____________ Diagnosis date ________ Treatment dates ________

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Medications	Reason	Amount/Dosage	Frequency	How Long

Producer name: ____________ Phone: ____________ Fax: ____________