LTC Ins. Pre-Qualification and Proposal Request Form

NORTHSTAR NETWORK INSURANCE AGENCY

California Long Term Care Insurance Services, Inc.

To email: Click Submit Below
To fax: Click Print below and fax to: 650-692-5204; Attn: Donna
Phone: 800-303-1527

Date:	**Broker Name:**	**State:**
Phone:	**Email:**	**License #:**

Client Name:	**Partner Name:**
Date of Birth: ◯ Male ◯ Female	**Date of Birth:** ◯ Male ◯ Female
Height: **Weight:**	**Height:** **Weight:**
Tobacco Use: ◯ Yes ◯ No	**Tobacco Use:** ◯ Yes ◯ No

High Blood Pressure	☐	**High Blood Pressure**	☐
Heart Attach/Atrial Fib	☐	**Heart Attach/Atrial Fib**	☐
Stroke/TIA	☐	**Stroke/TIA**	☐
Arthritis	☐	**Arthritis**	☐
Diabetes	☐	**Diabetes**	☐
Cancer	☐	**Cancer**	☐

Is client receiving Disability Benefits? ◯ **Yes** ◯ **No**

Please list current medications & reasons for taking:

Ever been declined for LTC Ins? ◯ **Yes** ◯ **No**
If yes, explain below.

Any hospital stays or surgeries in the last 10 years. ◯ **Yes** ◯ **No**
If yes, explain below.

Any procedures planned? ◯ **Yes** ◯ **No**
If yes, explain below.

Is client receiving Disability Benefits? ◯ **Yes** ◯ **No**

Please list current medications & reasons for taking:

Ever been declined for LTC Ins? ◯ **Yes** ◯ **No**
If yes, explain below.

Any hospital stays or surgeries in the last 10 years.
◯ **Yes** ◯ **No**
If yes, explain below.

Any procedures planned? ◯ **Yes** ◯ **No**
If yes, explain below.

Indicate Either	***Elimination Period***	***Benefit Period***	***Inflation Protection***	***Additional Riders***
◯ Daily Benefit $	◯ 0 day HHC	◯ 2 Year	◯ GPO/FPO	◯ Shared Care
◯ Monthly Benefit $	◯ 30 day Facility	◯ 3 Year	◯ Compound	◯ Restoration
	◯ 60 day Facility	◯ 4 Year	◯ Simple	◯ Return of Prem
	◯ 90 day Facility	◯ 5 or 6 Year	◯ None	◯ 10 Pay

Note: Benefits may vary by Carrier.

PRINT SUBMIT