American Insurnet

LTC Illustration Request

ILLUSTRATION REQUEST FORM

FAX TO AMERICAN INSURNET 513-287-7777

AGENT NAME **PHONE ( ) -** **FAX ( ) -** **EMAIL**	**CLIENT** **STATE OF RES.** **DOB** **SEX** **SMOKER? Yes No**
ADDRESS	**JOINT CLIENT** **DOB** **SEX** **SMOKER? Yes No**

QUOTE INFORMATION:

DAILY BENEFIT - $_____ (Max $250)

HOME HEALTH CARE - 0 / 50 / 100% of DB

WAITING PERIOD - 0 / 30 / 50 / 90 / 100 days

BENEFIT PERIOD - 2 / 3 / 4 / 5 / Lifetime

RIDERS:

Return of Premium
- Full ☐
- Limited ☐
- Shortened BP ☐

COLA
- Simple ☐
- Compound ☐

10 Pay ☐ **Single Pay** ☐
Home Health Care Only ☐
Endorsed Group Discount ☐

HEALTH ISSUES:

MEDICATION(S):

Does Client Own a Business?
C-Corp / S-Corp / Sole / Part / LLC / PSC

INSURABILITY PROFILE **Y N**

1. Is proposed covered by Medicaid (not Medicare?)..... ☐☐
2. Ever been medically diagnosed as having:
   - A. Diabetes under treatment with Insulin; Alzheimer's Disease; Persistent Forgetfulness; or senility?..... ☐☐
   - B. Multiple Sclerosis (MS); Parkinson's Disease; Stroke; Transient Ischemic Attack (TIA) within the past five years; multiple TIAs; TIA in combination with Diabetes or Heart Surgery; Muscular Dystrophy; or ALS (Lou Gehrig's Disease)?
   - C. Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); or positive HIV test?..... ☐☐
   - D. Metastic Cancer (spread from original site/location); Cirrhosis of the Liver?..... ☐☐
   - E. Emphysema/Chronic Obstructive Pulmonary Disease (COPD) in combination with any of the following: Current Smoking; Congestive Heart Failure (CHF); Asthma or Chronic Bronchitis?..... ☐☐
   - F. Congestive Heart Failure (CHF) in combination with any of the following: Heart Attack or Angina; Emphysema/COPD; Angioplasty or Heart Surgery; Asthma or Chronic Bronchitis; Diabetes; or Tuberculosis (TB)?..... ☐☐
3. Within the past 6 months, has the proposed ever had: Open Heart Surgery; Back or Spine Surgery..... ☐☐
4. Within the past 48 past months, have they had Cancer of the: Bone, Brain, Esophagus, Liver, Lung, Ovary, Pancreas, Stomach, or Testes?..... ☐☐
5. A. Ever use a Walker or a Wheelchair; Oxygen; Respirator; or Kidney Dialysis?..... ☐☐
   B. Ever need the assistance of or supervision by another person in performing any of the following activities: Moving in/out of bed or chair; Bathing; Dressing; Eating; Toileting; Bowel/Bladder control; walking?..... ☐☐
6. Height _____ Weight _____ (Client 1)
   Height _____ Weight _____ (Client 2)

SPECIAL ISSUES: