SUBMIT

One Resource Group

Long Term Care Department

LTC Coverage Quote Request Form

Agent Information

Name: _____

Phone: _____ Email: _____

Client Information	Client 1	Client 2
Name:		
State of Residence:		
Sex:		
DOB/Age:		
Marital Status:		

Benefit Information	Client 1	Client 2
Daily/Monthly Amount:		
Benefit Duration:		
Inflation Protection:		
Add. Options/Riders: (Home Health Elimination Period Waiver, Shared, Survivorship, Mode, etc.)		

Pre-Underwriting	Client 1	Client 2
Health Condition w/ Prescription Meds:		
Hospitalizations/Surgeries: (Date of last related treatment)		
Cancer: (Stage, any spreading, type of treatment, dates of treatment)		
Diabetes: (A1C score, insulin units per day, complications)		
Height/Weight:		
Tobacco Use:		

Please Select if apply:

Stroke or TIA None Emphysema None Heart Attack None Arthritis None

FOR ASSET BASED/LINKED BENEFIT QUOTE ONLY

Source of Funds: _____

Single Premium Amount: _____ Flex Pay Amount: _____ for _____ years

Desired Death Benefit: _____

When completed, please email (Lisa.Roose@orgcorp.com) or fax (260-207-9211) this questionnaire to Lisa Roose for case design.