

## Long Term Care Proposal Request

**Client:** \_\_\_\_\_ **Spouse:** \_\_\_\_\_  
 Gender \_\_\_\_ DOB \_\_\_\_\_ Tobacco - Y / N    Gender \_\_\_\_ DOB \_\_\_\_\_ Tobacco - Y / N

**Address:** \_\_\_\_\_  
 \_\_\_\_\_

**Phone:** \_\_\_\_\_  
**E-mail:** \_\_\_\_\_

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**Benefit Period:**     2 years    3 years    4 years    5 years    6 years    7 years    Lifetime

**Daily Benefit:**     \$50     \$100     \$150     \$200     \$250     \$300

**Elimination Period:**     0 day     30 day     60 days     90 days     180 Days

**Home Health Care:**     100%     80%     75%     50%

**Benefit Increase Rider:**     5% Compound     5% Simple     Purchase Option

**Other Riders:**     Survivorship     10 Year Limited Pay     Return of Premium

**Payment Mode:**     Annual     Semi-Annual     Quarterly

**Medical History & Additional Comments**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

<u>Client/Spouse</u>	<u>Medication</u>	<u>Dosage</u>	<u>Condition</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**PLEASE FAX COMPLETED FORM TO ARCH BROKERAGE AT ..... 314-849-9292**

