www.ufc.bz
FAX to (888) 857-1434

UFC UNIVERSAL Financial Consultants

(800) 506-4832

Long Term Care Quote Request Form:

Broker Name: _____
Address: _____
City: _____
State: _____ Zip: _____
Phone #: _____ Fax #: _____
Email: _____
Return Method: ◯ Email ◯ Fax

Insurance Company Preference if any: _____
Plan: _____
Client State: _____

Client:

Name: _____
Birthdate: _____ / _____ / _____
Sex: ☐ Male ☐ Female
Rate Class: ☐ Preferred ☐ Standard
Daily Benefit Amount: $
Home Care: ☐ 50% ☐ 75% ☐ 100%
Benefit Period: ☐ 2 year ☐ 4 year ☐ Lifetime ☐ other _____
Elimination Period (days): ☐ 0 ☐ 30 ☐ 90 ☐ other:
Inflation: ☐ Simple ☐ Compound ☐ COLI

Spouse:

Name: _____
Birthdate: _____ / _____ / _____
Sex: ☐ Male ☐ Female
Rate Class: ☐ Preferred ☐ Standard

Duplicate Benefits from Above? ☐ Yes ☐ No

If No, please complete the following:
Daily Benefit Amount: $
Home Care: ☐ 50% ☐ 75% ☐ 100%
Benefit Period: ☐ 2 year ☐ 4 year ☐ Lifetime ☐ other _____
Elimination Period (days): ☐ 0 ☐ 30 ☐ 90 ☐ other _____
Inflation: ☐ Simple ☐ Compound ☐ COLI

Pre-Underwriting:
Please list any additional comments, as well as any significant health conditions, associated medications AND/OR hospitalizations in the last 5 years.