THE THOMPSON AGENCY
Life Insurance Brokerage Service
INTEGRITY | TRUST | CREATIVITY | UNPARALLELED MARKETING SUPPORT

# Long-Term Care Insurance Proposal Request


## The Thompson Agency, Inc
800.842.8289 Fax: (860) 693-4547


**Agent Name:** _____

**Email:** _____

**Telephone:** _____ **Fax:** _____

| Client #1 | | | Client #2 | | |
|---|---|---|---|---|---|
| **Name:** | | | **Name:** | | |
| **Date of Birth:** | | | **Date of Birth:** | | |
| **Height:** | **Weight:** | | **Height:** | **Weight:** | |
| **Significant Medical History & Medications:** (Dates & Dosages) | | | **Significant Medical History & Medications:** (Dates & Dosages) | | |
| **Cane, Walker or Wheelchair? Yes ____ No ____** | | | **Cane, Walker or Wheelchair? Yes ____ No ____** | | |
| **Tobacco Use Last 12 months? Yes ____ No____** | | | **Tobacco Use Last 12 months? Yes____ No ____** | | |
| **Indicate if you have been medically diagnosed or treated for any of the conditions below: (Circle Yes or No)** | | | **Indicate if you have been medically diagnosed or treated for any of the conditions below: (Circle Yes or No)** | | |
| **Abnormal Blood Pressure** | **Yes** | **No** | **Abnormal Blood Pressure** | **Yes** | **No** |
| **Diabetes** | **Yes** | **No** | **Diabetes** | **Yes** | **No** |
| **Heart or Circulatory Disorder** | **Yes** | **No** | **Heart or Circulatory Disorder** | **Yes** | **No** |
| **Cancer** | **Yes** | **No** | **Cancer** | **Yes** | **No** |
| **Chronic Respiratory Disorder** | **Yes** | **No** | **Chronic Respiratory Disorder** | **Yes** | **No** |
| **Stroke or TIA** | **Yes** | **No** | **Stroke or TIA** | **Yes** | **No** |
| **Falling or Unstable Gait** | **Yes** | **No** | **Falling or Unstable Gait** | **Yes** | **No** |
| **Dizziness or Fainting** | **Yes** | **No** | **Dizziness or Fainting** | **Yes** | **No** |
| **Confusion or Memory Loss** | **Yes** | **No** | **Confusion or Memory Loss** | **Yes** | **No** |
| **Weakness or Fatigue** | **Yes** | **No** | **Weakness or Fatigue** | **Yes** | **No** |
| **Bladder or Bowel Control** | **Yes** | **No** | **Bladder or Bowel Control** | **Yes** | **No** |
| **Neurological Disorder** | **Yes** | **No** | **Neurological Disorder** | **Yes** | **No** |
| **Receiving physical therapy** | **Yes** | **No** | **Receiving physical therapy** | **Yes** | **No** |
| **Scheduled treatment or surgery** | **Yes** | **No** | **Scheduled treatment or surgery** | **Yes** | **No** |

## Requested Benefit Design:

| | |
|---|---|
| **Daily Benefit Amount: $_____** | **State: _____** |
| **Elimination Period:** **30 day ____ 60 days ____ 90 days ____ Other ____** | **Inflation Protection:** **5% Simple ____ 5% Compound ____ Other____** |
| **Benefit Period: # of years:____** | **Traditional LTCi _____ Partnership _____** |