PINNEY
INSURANCE

LTCI Quote Request

Income protection for life

Broker Name:_____***Broker Phone:***_____

Broker Address:_____

Client:_____ ***Date of Birth:*** _____ ***Smoker?*** ◯Y ◯N
◯preferred or ◯standard

Married? ◯Y ◯N ***Both Applying?*** ◯Y ◯N

Spouse:_____***Date of Birth:***_____ ***Smoker?*** ◯Y ◯N
◯ preferred or ◯standard

1. Nursing Facility Benefit:_____***Home & Community Benefit:***_____
Daily or Monthly Daily or Monthly

2. Elimination Period (Days): ◯30 ◯60 ◯90 ◯180 ◯365 ◯730
◯0 Day Home Care EP ◯Calendar Day EP

3. Benefit Duration (Yrs): ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯10 ◯Shared

4. Inflation Protection: ◯Compound ◯Simple ◯Future Purchase
◯Step-Rated ◯None

Carrier Preferences: _____
_____
_____

Specific Medical Conditions and Medication Prescribed:

_____

_____

_____

Toll-Free 800.823.4852 | Local 916.773.2800 | Fax 916.773.4484
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