

Northwest Planning, Inc. LONG TERM CARE QUOTE SHEET

DATE OF REQUEST: _____ DATE NEEDED: _____

AGENT INFORMATION

AGENT NAME: _____ COMPANY _____

PHONE: _____ FAX: _____

CLIENT INFORMATION

E-MAIL: _____

APPLICANT 1		SPOUSE	
AGE / DOB		AGE / DOB	
SMOKER Y/ N		SMOKER Y/ N	
STATE OF RESIDENCE		STATE OF RESIDENCE	
HEIGHT / WEIGHT		HEIGHT / WEIGHT	
MEDICAL CONDITIONS		MEDICAL CONDITIONS	
DATE OF ONSET		DATE OF ONSET	
MEDICATIONS & DOSAGE		MEDICATIONS & DOSAGE	
REASON FOR MEDICATION		REASON FOR MEDICATION	

COMPANY: _____ PRODUCT _____

PAYMENT MODE: *Circle One:* Annual Semi/Annual Quarterly Monthly

DAILY BENEFIT (*Min. \$50 - Max. \$250 in \$10 Increments*): \$ _____

BENEFIT PERIOD: _____ ELIMINATION PERIOD _____

COLA: COMPOUND _____ SIMPLE _____ NONE _____

ADDITIONAL RIDERS: _____

COMMENTS: _____

When completed please fax to 509-324-8892 or mail to Northwest Planning Inc,
West 507 Francis Avenue, Spokane, Washington 99205
509-324-8835 or 1-800-435-9577.