Instructions:

1. Download to desktop
2. Complete form
3. Save
4. Submit by clicking top right button

SUBMIT

Long-term Care Insurance Quote Request Form

Name:_____

State of Residence: _____

Date of Birth: _____

Gender: ☐ M ☐ F

Height: _____ **Weight:** _____

Tobacco Use: ☐ Y ☐ N

Spouse Name (if applying) _____

Date of Birth: _____

Gender: ☐ M ☐ F

Height: _____ **Weight:** _____

Tobacco Use: ☐ Y ☐ N

Phone: _____ **Email Address:** _____

Requested Monthly Benefit: ☐ $4,500 ☐ $6,000 ☐ $7,500 ☐ $9,000

Requested Lifetime Benefit: ☐ 2 Years ☐ 3 Years ☐ 4 Years ☐ 5 Years

Elimination Period: ☐ 90 Days ☐ 180 Days ☐ 365 Days

Have you ever been treated for or diagnosed with any of the following?
(Check all that apply)

☐ Neck/Back Disorder	☐ Diabetes w/insulin	☐ Rheumatoid Arthritis
☐ Heart Disease	☐ TIA/Stroke	☐ Dementia
☐ MS	☐ High Liver Enzymes	☐ Central Nervous System

Please provide details and any medications you are currently taking.

Return to:
The MPM Group
Phone: (859) 223-4973 I Fax: (859) 224-1288 I Email: dbaldwin@thempmgroupllc.com