



LONG-TERM CARE FACT FINDER

CLIENT PROFILE

To most effectively help find coverage options, we need to gather as much information as possible. Once completed, we will review all the information provided and begin formulating the most suitable recommendations available.

Date: _____

Name: _____ **DOB:** _____ Male Female

Rate Class: Preferred Standard Other (Specify) _____

Spouse Name: _____ **DOB:** _____ Male Female

Rate Class: Preferred Standard Other (Specify) _____

Spouse Applying? Yes No **If yes, Shared Benefit?** Yes No

Elimination Period: 30 days 60 days 90 days 180 days 365 days

Solve For: Monthly Premium Monthly Benefit **Amount:** _____

Benefit Length: 2 years 3 years 4 years 5 years Other (Specify) _____

Inflation Protection: 1% 2% 3% 4% 5% **Duration:** Lifetime 20yrs

Home Health Care Cash Benefit? Yes No **Amount:** 30% 40%

Waiver of Elimination Period For Home Health Care: Yes No

Level of Home Health Care: 100% 75% 50%

Level of Assisted Living: 100% 75% 50%

Return of Premium at Death Benefit: Yes No