

Quote Request

COMPLETE AND EMAIL TO: <u>mkaufman@CPSIMIS.com</u>		
AGENT NAME	DATE OF LTC CE COMPLETION	DATE NEEDED
PHONE NUMBER	EMAIL	

CLIENT NAME	STATE OF RESIDENCE	SPOUSE / PARTNER NAME	STATE OF RESIDENCE
DATE OF BIRTH	HEIGHT / WEIGHT	DATE OF BIRTH	HEIGHT / WEIGHT
MARITAL STATUS (Circle) S / M / Domestic Partner			
MEDICAL CONDITION OR HOSPITALIZATION (Last 10 Years)		MEDICAL CONDITION OR HOSPITALIZATION (Last 10 Years)	
SMOKER <input type="checkbox"/> Yes <input type="checkbox"/> No		SMOKER <input type="checkbox"/> Yes <input type="checkbox"/> No	
MEDICATIONS		MEDICATIONS	

PLAN DESIGN OR TARGETED PREMIUM ANNUALLY \$ _____

Benefit Amount \$ _____ (Typically \$4500) Benefit
 Duration _____ Years (Typically 3 years)
 Elimination Period _____ Days (Typically 90 days)

INFLATION
 CPS Recommendation 3% Comp (Typically used) None or GPO 5% Compound

RIDERS
 Shared Care
 Zero day elimination for Home Care