Phone Number: (516) 364-7171
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6800 Jericho Tpke.
Suite 200AW
Syosset, NY 11791
www.cpgllc.com

Long-Term Care Insurance Proposal Request

America's Long-Term Care Insurance Experts℠

Agent Name: _____

Email: _____

Telephone: _____ **Fax:** _____

Client #1		Client #2	
Name:		**Name:**	
Date of Birth:		**Date of Birth:**	
Height:	**Weight:**	**Height:**	**Weight:**
Significant Medical History & Medications: (Dates & Dosages)		**Significant Medical History & Medications:** (Dates & Dosages)	
Cane, Walker or Wheelchair? Yes ____ No ____		**Cane, Walker or Wheelchair? Yes ____ No ____**	
Tobacco Use Last 12 months? Yes ____ No____		**Tobacco Use Last 12 months? Yes____ No ____**	
Indicate if you have been medically diagnosed or treated for any of the conditions below: (Circle Yes or No)		**Indicate if you have been medically diagnosed or treated for any of the conditions below: (Circle Yes or No)**	
Abnormal Blood Pressure	**Yes No**	**Abnormal Blood Pressure**	**Yes No**
Diabetes	**Yes No**	**Diabetes**	**Yes No**
Heart or Circulatory Disorder	**Yes No**	**Heart or Circulatory Disorder**	**Yes No**
Cancer	**Yes No**	**Cancer**	**Yes No**
Chronic Respiratory Disorder	**Yes No**	**Chronic Respiratory Disorder**	**Yes No**
Stroke or TIA	**Yes No**	**Stroke or TIA**	**Yes No**
Falling or Unstable Gait	**Yes No**	**Falling or Unstable Gait**	**Yes No**
Dizziness or Fainting	**Yes No**	**Dizziness or Fainting**	**Yes No**
Confusion or Memory Loss	**Yes No**	**Confusion or Memory Loss**	**Yes No**
Weakness or Fatigue	**Yes No**	**Weakness or Fatigue**	**Yes No**
Bladder or Bowel Control	**Yes No**	**Bladder or Bowel Control**	**Yes No**
Neurological Disorder	**Yes No**	**Neurological Disorder**	**Yes No**
Receiving physical therapy	**Yes No**	**Receiving physical therapy**	**Yes No**
Scheduled treatment or surgery	**Yes No**	**Scheduled treatment or surgery**	**Yes No**

Requested Benefit Design:

Daily Benefit Amt: $_____ Monthly Benefit Amt: $ _____	**State: _____**
Elimination Period: **30 day ____ 60 days ____ 90 days ____ Other ____**	**Inflation Protection:** **5% Simple ____ 5% Compound ____ Other____**
Benefit Period: # of years:____	**Traditional LTCi _____ Partnership _____**
Couples Only - Shared Care: Yes _____ No _____	**Payment Option: Annual ____MO. ____ SA ____ QT ____**