

Marketing Group Long Term Care Proposal Request

Agent Name/Resident State		Phone	
<input type="checkbox"/> Fax the Proposal to this #: <input type="checkbox"/> Mail the proposal to: <input type="checkbox"/> E-Mail the Proposal @:			
Client Name		<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Domestic Partner	Clients Resident State
Client DOB/Age	HT:	WT:	Tobacco Use in past 5 yrs?: <input type="checkbox"/> Standard Health or <input type="checkbox"/> Preferred Health
Spouse Name			<i>Note: MG highly recommends quoting Standard Health for your clients</i>
Spouse DOB/Age	HT:	WT:	Tobacco Use in past 5 yrs?: <input type="checkbox"/> Standard Health or <input type="checkbox"/> Preferred Health
Select Carrier(s): <input type="checkbox"/> John Hancock <input type="checkbox"/> Genworth <input type="checkbox"/> MetLife <input type="checkbox"/> Prudential <input type="checkbox"/> MedAmerica <input type="checkbox"/> Allianz <input type="checkbox"/> Mutual of Omaha <input type="checkbox"/> Mass Mutual			
Benefit Amount	\$ _____	Home Care Options (% of Benefit Amount)	<input type="checkbox"/> None <input type="checkbox"/> 50% <input type="checkbox"/> 75% <input type="checkbox"/> 100%
	<input type="checkbox"/> Daily or <input type="checkbox"/> Monthly Benefit		
Benefit Period	<input type="checkbox"/> 2 Yrs <input type="checkbox"/> 3 Yrs <input type="checkbox"/> 4 Yrs <input type="checkbox"/> 5 Yrs <input type="checkbox"/> 6 Yrs <input type="checkbox"/> 7 Yrs <input type="checkbox"/> 10 Yrs <input type="checkbox"/> Lifetime		
Elimination Period	<input type="checkbox"/> 30 Days <input type="checkbox"/> 45 Days (<i>MetLife only</i>) <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days <input type="checkbox"/> 180 Days		
Inflation Protection	<input type="checkbox"/> 5% Compound <input type="checkbox"/> 5% Simple <input type="checkbox"/> Future Purchase Option <input type="checkbox"/> None <input type="checkbox"/> Other _____		
Optional Riders	<input type="checkbox"/> Indemnity Benefits <input type="checkbox"/> Elimination Period Enhancement <input type="checkbox"/> Shared Care <input type="checkbox"/> Waiver of HHC Elimination <input type="checkbox"/> Return of Premium <input type="checkbox"/> Other: _____		
Payment Options	<input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annl <input type="checkbox"/> Qtly <input type="checkbox"/> Mthly	Limited Pay	<input type="checkbox"/> 10-pay <input type="checkbox"/> Pay to 65
CLIENT: Health Information Health Issues or Disease Medications w/dosage Hospitalizations in past 5 years		SPOUSE: Health Information Health Issues or Disease Medications w/dosage Hospitalizations in past 5 years	
Today's Date:		I need this Proposal no later than:	
Fax this request to MG		To Contact MG By Phone	
MG Marketing Team FAX.....817-731-8200		MG LTC Hotline817-731-7373 tim@hyoder.com	