

**LONG TERM CARE PROPOSAL REQUEST**

NAME \_\_\_\_\_ DOB \_\_\_\_\_ SMOKER \_\_\_\_\_ STATE \_\_\_\_\_ U/W CLASS \_\_\_\_\_  
PREF SELECT STAND  
SPOUSE \_\_\_\_\_ DOB \_\_\_\_\_ SMOKER \_\_\_\_\_ STATE \_\_\_\_\_ U/W CLASS \_\_\_\_\_  
PREF SELECT STAND

**BERKSHIRE or STATE LIFE (AGE NEAREST)**  
**(PLEASE CIRCLE COMPANY WANTED)**  
**NURSING HOME**  
ENDORSED GROUP DISCOUNT: Y N

DAILY BENEFIT \_\_\_\_\_ (40-300)  
ELIMINATION: 0 30 90 180  
BENEFIT PERIOD: 2 3 4 5 6 10 LT

**HOME HEALTH** Y N

**RIDERS:**

INDEMNITY: Y N HHC W/P: Y N  
COLA: NONE SIMPLE COMPOUND  
NONFOR: Y N RETURN OF PREM: Y N  
HCBC 1<sup>ST</sup> DAY COV: Y N MONTHLY BENEFIT: Y N  
PAYMENT OPTIONS: LT 10 TO 65

**GE CAPITOL (ACTUAL AGE)**

DAILY BENEFIT \_\_\_\_\_ (50-400)  
ELIMINATION: 30 90 180  
BENEFIT PERIOD: 730 1095 1460 1825  
2190 2920 3650 LT

**HOME HEALTH:** 50% 100%

**RIDERS:**

COLA: NONE EQUAL COMPOUND  
RESTORATION OF BENEFITS: Y N  
SURVIVORSHIP: Y N  
HCBC WAIVER OF ELIM: Y N  
MONTHLY BENEFIT: Y N  
NON FORFIETURE: Y N  
PAYMENT OPTIONS: LT 10

**JOHN HANCOCK (ACTUAL AGE)**

**NURSING HOME:**

DAILY BENEFIT \_\_\_\_\_ (50-500)  
ELIMINATION: 30 60 90 180 365  
BENEFIT PERIOD: 2 3 4 5 6 10 LT

**HOME HEALTH**

SAME AS NURSING HOME BENEFIT

**RIDERS:**

COLA: GPO SIMPLE COMPOUND CASH BENEFIT: Y N  
NON FOR: NONE FULL LTD MTHLY BENEFIT: Y N  
SURVIVORSHIP: Y N ELIM WAIVER HHC: Y N  
PAYMENT OPTIONS: LT 10 TO 65

**HEALTH HISTORY NOTES:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**AGENT INFORMATION:**

**NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
**ADDRESS:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_  
\_\_\_\_\_  
**FAX:** \_\_\_\_\_  
**FAX MAIL E-MAIL** \_\_\_\_\_

**FOR OFFICE USE ONLY:**  
**DATE REQUESTED:** \_\_\_\_\_  
**DATE COMPLETED:** \_\_\_\_\_  
**FAXED MAILED EMAILED**