Long-Term Care Insurance Proposal Request

Borden Hamman

Main: **(800) 492-9190** Fax Number: **214-302-8198**
www.bordenhamman.com **marketing@bordenhamman.com**

BARRY J. FISHER INSURANCE MARKETING
A Borden Hamman Company

AGENT NAME: Steve Shorr Lic. # NPC #2710578
Email: Steve@SteveShorr.com
TELEPHONE: 310.519.1335 FAX None
ADDRESS: 1027 W. 11th Street # 3, San Pedro, CA 90731
Marketing Rep: _____ Date Requested: _____

CLIENT #1		CLIENT #2	
NAME: ☐ M ☐ F		NAME: ☐ M ☐ F	
DATE OF BIRTH:		DATE OF BIRTH:	
HEIGHT:	WEIGHT:	HEIGHT:	WEIGHT:
Married or Registered Domestic Partner? ☐ Yes ☐ No		Is Spouse or Partner Applying for Coverage now? ☐ Yes ☐ No	
ANNUAL HOUSEHOLD INCOME (Important!): ☐ Under $50K ☐ $50 - $100K ☐ $100K Plus			
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:		INDICATE IF YOU HAVE BEEN MEDICALLY DIAGNOSED OR TREATED FOR ANY OF THE CONDITIONS BELOW:	
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
Respiratory Disorder	◯ Yes ◯ No	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
Depression/anxiety	◯ Yes ◯ No	Depression/anxiety	◯ Yes ◯ No

REQUESTED BENEFIT DESIGN: Please complete our Income & Assets Form
So we can assist you with Benefits, waiting period etc.

Daily Benefit Amount: $	State of Residence
Elimination Period: ☐ 0 day ☐ 30 days ☐ 90 days	Inflation:
Benefit Pool: # of years:	
Carrier Preference:	Payment Options: ☐ Lifetime Pay ☐ Limited Pay