

Long-Term Care Insurance Proposal Request



BORDEN HAMMAN

Borden Hamman



BARRY J. FISHER
INSURANCE MARKETING
A Borden Hamman Company

Main: (800) 492-9190
www.bordenhamman.com

Fax Number: 214-302-8198
marketing@bordenhamman.com

AGENT NAME: _____ Lic. # _____

Email: _____

TELEPHONE: _____ FAX _____

ADDRESS: _____

Marketing Rep: _____ Date Requested: _____

CLIENT #1		CLIENT #2	
NAME: _____	M	F	NAME: _____
DATE OF BIRTH: _____		DATE OF BIRTH: _____	
HEIGHT: _____	WEIGHT: _____	HEIGHT: _____	WEIGHT: _____
Married or Registered Domestic Partner? <input type="radio"/> Yes <input type="radio"/> No		Is Spouse or Partner Applying for Coverage now? <input type="radio"/> Yes <input type="radio"/> No	
ANNUAL HOUSEHOLD INCOME (Important!): <input type="checkbox"/> Under \$50K <input type="checkbox"/> \$50 - \$100K <input type="checkbox"/> \$100K Plus			
SIGNIFICANT MEDICAL HISTORY & MEDICATIONS (Dates & Dosages)		SIGNIFICANT MEDICAL HISTORY & MEDICATIONS (Dates & Dosages)	
CANE, WALKER OR WHEELCHAIR? <input type="radio"/> Yes <input type="radio"/> No		CANE, WALKER OR WHEELCHAIR? <input type="radio"/> Yes <input type="radio"/> No	
Tobacco Use Last 12 months? <input type="radio"/> Yes <input type="radio"/> No		Tobacco Use Last 12 months? <input type="radio"/> Yes <input type="radio"/> 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	<input type="radio"/> Yes <input type="radio"/> No	Abnormal Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No
Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No
Heart or Circulatory Disorder	<input type="radio"/> Yes <input type="radio"/> No	Heart or Circulatory Disorder	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Cancer	<input type="radio"/> Yes <input type="radio"/> No
Respiratory Disorder	<input type="radio"/> Yes <input type="radio"/> No	Respiratory Disorder	<input type="radio"/> Yes <input type="radio"/> No
Stroke or TIA	<input type="radio"/> Yes <input type="radio"/> No	Stroke or TIA	<input type="radio"/> Yes <input type="radio"/> No
Falling or Unstable Gait	<input type="radio"/> Yes <input type="radio"/> No	Falling or Unstable Gait	<input type="radio"/> Yes <input type="radio"/> No
Dizziness or Fainting	<input type="radio"/> Yes <input type="radio"/> No	Dizziness or Fainting	<input type="radio"/> Yes <input type="radio"/> No
Confusion or Memory Loss	<input type="radio"/> Yes <input type="radio"/> No	Confusion or Memory Loss	<input type="radio"/> Yes <input type="radio"/> No
Weakness or Fatigue	<input type="radio"/> Yes <input type="radio"/> No	Weakness or Fatigue	<input type="radio"/> Yes <input type="radio"/> No
Bladder or Bowel Control	<input type="radio"/> Yes <input type="radio"/> No	Bladder or Bowel Control	<input type="radio"/> Yes <input type="radio"/> No
Neurological Disorder	<input type="radio"/> Yes <input type="radio"/> No	Neurological Disorder	<input type="radio"/> Yes <input type="radio"/> No
Receiving physical therapy	<input type="radio"/> Yes <input type="radio"/> No	Receiving physical therapy	<input type="radio"/> Yes <input type="radio"/> No
Scheduled treatment or surgery	<input type="radio"/> Yes <input type="radio"/> No	Scheduled treatment or surgery	<input type="radio"/> Yes <input type="radio"/> No
Depression/anxiety	<input type="radio"/> Yes <input type="radio"/> No	Depression/anxiety	<input type="radio"/> Yes <input type="radio"/> No

REQUESTED BENEFIT DESIGN:

Daily Benefit Amount: \$ _____	State of Residence _____
Elimination Period: <input type="checkbox"/> 0 day <input type="checkbox"/> 30 days <input type="checkbox"/> 90 days	Inflation: _____
Benefit Pool: # of years: _____	Payment Options: <input type="checkbox"/> Lifetime Pay <input type="checkbox"/> Limited Pay
Carrier Preference: _____	