

**Complete and Return by Fax to (949) 225-7159 or email to [ltcsales@cpsinsurance.com](mailto:ltcsales@cpsinsurance.com)**

Agent Name	License Number	Date Needed
Phone Number	Email	

<b>Carrier Preference</b> <input type="checkbox"/> <b>Assurity</b> <input type="checkbox"/> <b>John Hancock Partnership</b> <input type="checkbox"/> <b>Mutual of Omaha</b> <input type="checkbox"/> <b>Genworth</b> <input type="checkbox"/> <b>MedAmerica</b> <input type="checkbox"/> <b>Prudential</b> <input type="checkbox"/> <b>Genworth Partnership</b> <input type="checkbox"/> <b>MetLife</b> <input type="checkbox"/> <b>John Hancock</b> <input type="checkbox"/> <b>MetLife Partnership</b>			
Client Name	State of Residence	Spouse / Partner Name	State of Residence
Date of Birth	Marital Status (circle) S M Domestic Partner	Height / Weight	Date of Birth
Serious illness, accident or hospitalization in last 10 years		Serious illness, accident or hospitalization in last 10 years	
Smoker <input type="checkbox"/> Yes <input type="checkbox"/> No		Smoker <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medications _____		Medications _____	
<b>Plan Design</b> <input type="checkbox"/> COMPREHENSIVE <input type="checkbox"/> FACILITY ONLY  Benefit Amount \$ _____ <input type="checkbox"/> Daily <input type="checkbox"/> Monthly Benefit Duration _____ YEARS <input type="checkbox"/> LIFETIME Elimination Period _____ DAYS Inflation <input type="checkbox"/> 5% COMPOUND <input type="checkbox"/> 5% SIMPLE <input type="checkbox"/> NONE  Riders <input type="checkbox"/> SHARED CARE <input type="checkbox"/> RETURN OF PREMIUM <input type="checkbox"/> INDEMNITY <input type="checkbox"/> RESTORATION OF BENEFITS  _____		<b>Plan Design</b> <input type="checkbox"/> Same as Client <input type="checkbox"/> COMPREHENSIVE <input type="checkbox"/> FACILITY ONLY  Benefit Amount \$ _____ <input type="checkbox"/> Daily <input type="checkbox"/> Monthly Benefit Duration _____ YEARS <input type="checkbox"/> LIFETIME Elimination Period _____ DAYS Inflation <input type="checkbox"/> 5% COMPOUND <input type="checkbox"/> 5% SIMPLE <input type="checkbox"/> NONE  Riders <input type="checkbox"/> SHARED CARE <input type="checkbox"/> RETURN OF PREMIUM <input type="checkbox"/> INDEMNITY <input type="checkbox"/> RESTORATION OF BENEFITS  _____	
Limited Pay Options <input type="checkbox"/> 10 PAY <input type="checkbox"/> PAID AT 65		Limited Pay Options <input type="checkbox"/> 10 PAY <input type="checkbox"/> PAID AT 65	