



Long Term Care Insurance Quote Request

1615 Hill Road · Suite H
 Novato CA 94947
 415-897-9437
 www.MoyerIns.com

Fax to: 415-892-9043

Email: Judy@MoyerIns.com

CA Lic. #0E83650

Attn: _____ Cell: ____ (____) _____
 Address: _____ Phone: __ (____) _____
 City, State, Zip: _____ Fax: ____ (____) _____
 Email: _____

	Primary Insured	Secondary Insured (if any/relationship)
Name		
Date of Birth		
Smoker? If yes, how many per day? If quite, when?		
General Health: Surgeries: Type/when/outcome? Prescriptions: Name/dosage/for what? <i>Please add page(s), if needed</i>		
Benefit Requested (if you are unsure, please call to discuss options)	\$ _____/Day	\$ _____/Day
Benefit Years	1__ 2__ 3__ 4__ 5__ 6__ Unlimited__	1__ 2__ 3__ 4__ 5__ 6__ Unlimited__
Elimination Period (days)	0__ 30__ 60__ 90__	0__ 30__ 60__ 90__
Increase in the Cost of Living Options	Simple__ Compound__	Simple__ Compound__
Include Home Care?	Yes__ No__	Yes__ No__

This information is confidential. However, if you prefer to discuss any of the above options or conditions privately, please call us directly at 415-897-9437.

Internal Use: _____ Initial: _____ Date: _____