

LONG TERM CARE INSURANCE WORKSHEET

Name: _____ **Phone Number:** _____
State of Residence: _____ **Date of Birth:** _____
Street Address: _____ **Height:** _____
City, St, Zip: _____ **Weight:** _____
Smoker: Yes No
Married: Yes No **If Yes, is Spouse Applying?:** Yes * No
*If spouse is applying, please complete section on back.

HOSPITALIZATION IN LAST 10 YEARS:		
Dates	Reasons	Results

Please list below any medical conditions, along with medications you are taking, and the dosage amount.

Medical Conditions:	Treatment Dates:	Medications:	Dosage:

BENEFITS TO BE QUOTED: (Please see page 9 or call us for assistance and/or explanation.)

(Circle your selections)

Number of Years to receive benefits: 2 3 4 5 6 8 10 Lifetime
Daily Benefit Requested: \$100 \$150 \$200 \$250 \$300
Monthly Maximum Benefit (rather than Daily) Yes No
Inflation Protection Option: None Simple Compound
Elimination Period: 30 Days 90 Days 180 Days
Reduced Home Care: Yes No
Survivorship Benefit: None 7 year 10 year

Ohio Dental Association Insurance Agency
 1370 Dublin Road
 Columbus, OH 43215-1098
 (614) 486-2700
 1-800-282-1526

LONG TERM CARE INSURANCE WORKSHEET (cont.)

SPOUSE SUPPLEMENT:

Name: _____
State of Residence: _____
Street Address: _____
City, St, Zip: _____

Date of Birth: _____
Height: _____
Weight: _____
Smoker: Yes No

HOSPITALIZATION IN LAST 10 YEARS:

Dates	Reasons	Results

Please list below any medical conditions, along with medications you are taking, and the dosage amount.

Medical Conditions:	Treatment Dates:	Medications:	Dosage:

BENEFITS TO BE QUOTED:

(Please see page 9 or call us for assistance and/or explanation.)

(Circle your selections)

Number of Years to receive benefits:	2	3	4	5	6	8	10	Lifetime
Daily Benefit Requested:	\$100	\$150	\$200	\$250	\$300			
Monthly Maximum Benefit (rather than Daily)	Yes	No						
Inflation Protection Option:	None	Simple	Compound					
Elimination Period:	30 Days	90 Days	180 Days					
Reduced Home Care:	Yes	No						
Survivorship Benefit:	None	7 year	10 year					