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## LTC/Disability Quote Request

Full Name:				Gender:		DOB:		Tobacco:	Yes / No					
City:		County:				State, Zip:								
Height:		Weight:		Occupation Duties:										
Any Medical Problems (List Person with condition and as much info as possible) or Comments:														
<b>LTC Coverage Information</b>														
Daily Benefit Amount (\$10 increments):	Payment Type		Elimination Period			Benefit Period:								
\$	<input type="checkbox"/> Lifetime		<input type="checkbox"/> 0 Day			<input type="checkbox"/> 2 yr		<input type="checkbox"/> 3 yr						
	<input type="checkbox"/> 10 Pay		<input type="checkbox"/> 30 Day			<input type="checkbox"/> 4 yr		<input type="checkbox"/> 5 yr						
	<input type="checkbox"/> 20 Pay		<input type="checkbox"/> 90 Day			<input type="checkbox"/> 6 yr		<input type="checkbox"/> 10 yr						
			<input type="checkbox"/> 180 Day			<input type="checkbox"/> Lifetime								
<b>Riders</b>														
<input type="checkbox"/> Home Health Care <input type="checkbox"/> HCBF WP <input type="checkbox"/> HCBF First Day <b>Benefit Increase Rider</b> <input type="checkbox"/> Compound 5% <input type="checkbox"/> Simple 5%					<input type="checkbox"/> Return of Premium <input type="checkbox"/> Restoration of Benefits <input type="checkbox"/> Shared Benefit Amount <input type="checkbox"/> Endorsed Group Discount					You may only choose one of the following: <input type="checkbox"/> Facility & HCBC Indemnity <input type="checkbox"/> Facility Only Indemnity <input type="checkbox"/> Monthly HCBC Benefit <input type="checkbox"/> Facility Only Indemnity & Monthly HCBC				
<b>Individual Disability Policy</b>														
Who will pay Premium?	<input type="checkbox"/> Employer <input type="checkbox"/> Employee		Monthly Benefits:	\$										
Elimination Period:	<input type="checkbox"/> 60 <input type="checkbox"/> 90 <input type="checkbox"/> 180 <input type="checkbox"/> 365		Benefit Period:	<input type="checkbox"/> 2yrs <input type="checkbox"/> 5yrs <input type="checkbox"/> to 65 <input type="checkbox"/> 66/67										
Benefit Riders:	<input type="checkbox"/> SSIB _____ <input type="checkbox"/> Residual Benefits <input type="checkbox"/> COLA <input type="checkbox"/> Non-Cancelable <input type="checkbox"/> Return of Premium <input type="checkbox"/> CAT _____ <input type="checkbox"/> Future Purchase Option <input type="checkbox"/> Own Occ. <input type="checkbox"/> Lifetime <input type="checkbox"/> No Riders													
<b>Overhead Expense Policy</b>														
Monthly Benefit	\$	Elimination Period:	<input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90		Benefit Period	<input type="checkbox"/> 12mos <input type="checkbox"/> 18mos <input type="checkbox"/> 24mos								
Benefit Riders:	<input type="checkbox"/> Residual Benefits <input type="checkbox"/> Future Purchase Option													
Agent Name:					Agent Email:									
Phone:				Fax:										