WENTWORTH
FINANCIAL PARTNERS

PROPOSAL REQUEST
LONG TERM CARE

Date: _____ Client Meeting Date: _____

AGENT INFORMATION

Name: _____

Phone: _____ Fax: _____

Email: _____

INSURED INFORMATION

Name: _____

Occupation: _____

DOB: _____ Height: _____ Weight: _____ State: _____

☐ Single ☐ Married ☐ Domestic Partner *if domestic partner, how long:* _____

BENEFIT DETAILS

Daily Benefit Amount: _____ Benefit Period: _____

Elimination Period: _____ Inflation Protection: _____

Riders: _____

Business Owner: ☐ Yes ☐ No *If yes, please select business type below:*

☐ C-Corp ☐ S-Corp ☐ Professional ☐ Corp LLC/LLP ☐ Self-Employed

Total Household Income: _____ Funding Strategy: _____

Premium Budget: _____ Payment Options: _____

Continued on the next page

PROPOSAL REQUEST LONG TERM CARE
continued

UNDERWRITING INFORMATION

Tobacco Use in Last 5 Years ☐ Yes ☐ No

Health Conditions and Diagnosis Dates: _____

_____

_____

_____

_____

Medications, Dosage, Dated Started, and Reason for Taking: _____

_____

_____

_____

_____

Hospitalizations in Last 5 Years including Admission Date and Reason: _____

_____

_____

_____

_____

Other Heath Information: _____

_____

_____

_____

Return the completed form to wfphelp@wentworthfp.com

Call us with questions at (855) 757-5433