LONG TERM CARE INSURANCE PROPOSAL REQUEST  info@ephc.com

Economic Planning Health Corporation (631)345-2300 / Fax (631)205-1501
Contact Name: _____
Telephone #: _____
Mailing Address:
_____
Fax #: _____ **Email address:** _____

1) **Client's Name:** _____
2) **Gender:** F M **Date of Birth:** _____

Non-tobacco Cigarette Smoker Cigars - How often? _____ Chewing Tobacco
Height: _____ Weight _____ State of Residence: _____
Medical History: (IMPORTANT - include date of diagnosis, what kind of treatment and length of treatment, medications -duration and dosage. NOTE - the more details provided, the more an accurate quote will be given)
_____
_____
_____
_____
_____
_____
Have you ever taken an antidepressant medication or received counseling for any reason?
Yes or No
Please provide details:
_____

3) **Spouse's Name:** _____
4) **Gender:** F M **Date of Birth:** _____

Non-tobacco Cigarette Smoker Cigars - How often? _____ Chewing Tobacco
Height: _____ Weight _____ State of Residence: _____
Medical History: (IMPORTANT - include date of diagnosis, what kind of treatment and length of treatment, medications -
Duration and dosage. NOTE - the more details provided, the more an accurate quote will be given)
_____
_____
_____
_____
_____
_____
Has you ever taken an antidepressant medication or received counseling for any reason?
Yes or No
Please provide details:
_____
Single, Married or spouse is not applying
Benefit Amount:
1) _____ Daily Monthly
2) _____ Daily Monthly
Benefit Period: 2yrs 3yrs 4yrs 5yrs 7yrs 8yrs 10yrs Unlimited
(If available)
Elimination Period: 0 day 30 days 60 days 90 days 180days

Riders:
Shared Care
Waiver of premium
Return of premium
Simple COLA or Compound COLA
Period/Home Health Care