

QUICK REQUEST – LONG TERM CARE CHOICE INDIVIDUAL

This is not an application and does not bind any coverage. The application and policy will be issued based on the Residence Address below.

Instructions:

- Once the sale is made, prepare the client for next steps (A representative will contact the client by phone to schedule and complete the application.)
- Complete the HIPAA authorization and any state required forms.
- Fax all forms to Genworth LTCI Quick Request Processing Team at **866 360.9355**
- For clients choosing the Conditional Insurance Agreement, please obtain a check or Electronic Funds Transfer (EFT) form. **Overnight** all paperwork to: Genworth LTCI Quick Request Team, 3100 Albert Lankford Drive, Lynchburg, VA 24501-4948.

CLIENT PROFILE

Print Name A. _____		Date _____	Social Security # A. _____ - _____ - _____	
B. _____		____/____/____	B. _____ - _____ - _____	
Couples Discount Quoted <input type="radio"/> Yes <input type="radio"/> No				
Date of Birth A. _____		Gender A. <input type="radio"/> Male <input type="radio"/> Female	A. <input type="radio"/> Married <input type="radio"/> Single <input type="radio"/> Widowed	
B. _____		B. <input type="radio"/> Male <input type="radio"/> Female	B. <input type="radio"/> Married <input type="radio"/> Single <input type="radio"/> Widowed	
Residence Address (required)			State in which Application is Signed (if different from resident state)	
City _____		State _____	Zip Code _____	
Preferred Phone (required)		Alternate Phone		Best Time to Call
A. _____ <input type="radio"/> Home		A. _____ <input type="radio"/> Work		<input type="radio"/> Morning <input type="radio"/> Afternoon <input type="radio"/> Evening
B. _____ <input type="radio"/> Home		B. _____ <input type="radio"/> Work		

LTCI COVERAGE (To submit a request for different benefits for Applicants A & B use two individual forms.)

Daily Maximum (\$5 increments) \$ _____	Minimum \$50 Maximum \$400
Benefit Multiplier <input type="radio"/> 730 <input type="radio"/> 1,095 <input type="radio"/> 1,460 <input type="radio"/> 2,190 <input type="radio"/> Unlimited	
Elimination/Waiting Period <input type="radio"/> 30 days <input type="radio"/> 90 days	
Benefit Increases <input type="radio"/> 5% Compound Increases <input type="radio"/> 5% Equal (simple) Increases <input type="radio"/> No Increases	
Nonforfeiture Benefits <input type="radio"/> Yes <input type="radio"/> No	
Restoration of Benefits <input type="radio"/> Yes <input type="radio"/> No	
Revised Elimination Period - If selected, the Elimination Period will also apply to Home and Community Based Care Benefits. If not selected, the elimination period will not apply to Home and Community Based Care. <input type="radio"/> Yes	

Survivorship Benefit

Coverage will include Survivorship benefit unless rejected at right: Survivorship benefit rejected

A. MultiLife Group Number: _____	B. MultiLife Group Number: _____
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Replacement Yes No (if yes, complete a replacement form) If YES, whose coverage is being replaced: **A** **B**

PAYMENT INFORMATION

Preferred Health Discount Quoted A. <input type="radio"/> Yes <input type="radio"/> No	Limited Pay Option A. <input type="radio"/> None <input type="radio"/> 10-Pay <input type="radio"/> Pay-to-65
B. <input type="radio"/> Yes <input type="radio"/> No	B. <input type="radio"/> None <input type="radio"/> 10-Pay <input type="radio"/> Pay-to-65
Quoted Premium Amount A. \$ _____	Payment Plan (choose one) <input type="radio"/> Annual <input type="radio"/> Semi-Annual <input type="radio"/> Quarterly <input type="radio"/> Monthly Bank Draft
B. \$ _____	Payment Plan (choose one) <input type="radio"/> Annual <input type="radio"/> Semi-Annual <input type="radio"/> Quarterly <input type="radio"/> Monthly Bank Draft

REP INFORMATION

Rep Name	Rep Phone
Rep Social Security Number	Rep Fax
Rep E-mail	Agency/Firm/Branch Number

AGENT ATTESTATION

Before you complete the process to submit a Quick Request, you must authorize the Quick Request call team to contact the client on your behalf for the purposes of collecting medical information, and transcribing the benefits, options and riders contained within this request onto an application for long term care insurance as well as provide your signature on the completed application.

It is very important that you review the statements below before providing your signature. By providing your signature you are attesting that you agree to the statements below.

By submitting this Quick Request and signing below, you attest to the following:

- I acknowledge that my client will be contacted on my behalf for the purpose of collecting medical history information.
- I understand that during my client’s interview for completing the application, the product features and benefits will not be discussed. The interviewer cannot bind coverage, sell, solicit, or negotiate on my behalf.
- I understand that questions relating to these functions will be referred back to me as the soliciting agent.
- I have discussed voice signature with the client.
- I have reviewed the features and benefits of the proposed coverage with my client(s) and those features and benefits are attached to this Quick Request for transfer to the completed application for insurance.
- I have discussed the effective date of coverage and the effect of the Conditional Insurance Agreement coverage, if applicable.
- I have provided copies of the outline of coverage, shoppers guide, health information authorization and other state required forms and disclosures to my client(s).

In addition to the authorizations referenced in the preceding paragraphs, signing below will constitute my legally binding signature on the completed application and on all supporting documentation for the client(s) referenced in the quick request associated with this attestation.

I hereby agree to the provisions in this attestation and affix my signature to the attestation and those documents referenced therein by signing below.

List other health insurance policies sold by you to the applicant.

Applicant A: _____ Applicant B: _____

List health insurance policies sold by you to the applicant in the last five years that are no longer in force.

Applicant A: _____ Applicant B: _____

Representative/Agent Signature

Date

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Insurance and annuity products:	• Are not deposits.	• Are not insured by the FDIC or any other federal government agency.
	• May decrease in value.	• Are not guaranteed by the bank or its affiliates.