

# LTCI QUICK REQUEST FORM – PRIVILEGED CHOICE<sup>SM</sup> SHARED

**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, Electronic Funds Transfer (EFT) form, or an initial Credit Card Authorization form. **Overnight** all paperwork to: Genworth LTCI Quick Request Team, 3100 Albert Lankford Drive, Lynchburg, VA 24501-4948.

\*Credit card payments are not available in AK, MD, NC, NJ and PA.

**CLIENT PROFILE**

Print Name <b>A.</b> _____ <b>B.</b> _____		Date ____/____/____	Social Security # <b>A.</b> _____ - _____ - _____ <b>B.</b> _____ - _____ - _____	
Date of Birth <b>A.</b> _____ (mm/dd/yyyy) <b>B.</b> _____	Gender <b>A.</b> <input type="radio"/> Male <input type="radio"/> Female <b>B.</b> <input type="radio"/> Male <input type="radio"/> Female	<b>A.</b> <input type="radio"/> Married <input type="radio"/> Single <input type="radio"/> Widowed <b>B.</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) <b>A.</b> _____ <input type="radio"/> Home <b>B.</b> _____ <input type="radio"/> Home		Alternate Phone <b>A.</b> _____ <input type="radio"/> Work <b>B.</b> _____ <input type="radio"/> Work		Best Time to Call <input type="radio"/> Morning <input type="radio"/> Afternoon <input type="radio"/> Evening

**LTCI COVERAGE**

Monthly Maximum (\$100 increments) \$ _____	<i>Minimum \$1,500 (\$1,800 in WI; \$1,600 in MA; \$3,900 for MA Health Plans; \$2,300 in VT and \$3,200 in SD) Maximum \$12,000</i>		
Benefit Multiplier <input type="radio"/> 48* <input type="radio"/> 72 <input type="radio"/> 96 <input type="radio"/> 120 <input type="radio"/> 144 <input type="radio"/> 192 <input type="radio"/> 240	* Not available in AZ & MA		
Elimination/Waiting Period <input type="radio"/> 30 days <input type="radio"/> 90 days <input type="radio"/> 180 days*	* Not available in CT, GA, SD, VT		
Inflation Protection <input type="radio"/> 5% Compound Increases <input type="radio"/> 5% Equal (simple) Increases <input type="radio"/> 3% Compound Increases* <input type="radio"/> No Increases	* Not available in CT		
7 Year Survivorship Option* <input type="radio"/> Yes <input type="radio"/> No	* Only available if both spouses apply and issued		
Nonforfeiture Benefits <input type="radio"/> Yes <input type="radio"/> No	Restoration of Benefits <input type="radio"/> Yes <input type="radio"/> No		
<b>A.</b> MultiLife Group Number: _____	<b>B.</b> MultiLife Group Number: _____ (Not available in OH, NC and PA)		
Replacement <input type="radio"/> Yes <input type="radio"/> No (if yes, complete a replacement form)	If YES, whose coverage is being replaced: <input type="radio"/> <b>A</b> <input type="radio"/> <b>B</b>		

**PAYMENT INFORMATION**

Preferred Health Discount Quoted <b>A.</b> <input type="radio"/> Yes <input type="radio"/> No	<b>B.</b> <input type="radio"/> Yes <input type="radio"/> No
Quoted Premium Amount \$ _____	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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<b>Insurance and annuity products:</b>	<b>• Are not</b> deposits.	<b>• Are not</b> insured by the FDIC or any other federal government agency.
	<b>• May</b> decrease in value.	<b>• Are not</b> guaranteed by the bank or its affiliates.