

LTCI QUICK REQUEST FORM – NEW YORK PARTNERSHIP PLUS

This is not an application and does not bind any coverage. The Client must be a New York resident, reflected in the Residence Address section below, to apply for this policy.

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

LTCI COVERAGE

Daily Maximum <i>(\$5 increments)</i> \$ _____ <i>Minimum \$230 (2010) Maximum \$400</i>	Benefit Multiplier		Elimination/Waiting Period	
	Dollar for Dollar 50	<input type="radio"/> 548 days	<input type="radio"/> 30 days	<input type="radio"/> 60 days
	Dollar for Dollar 100:	<input type="radio"/> 730 days	<input type="radio"/> 30 days	<input type="radio"/> 60 days
	Total Asset 50:	<input type="radio"/> 1,095 days	<input type="radio"/> 30 days	<input type="radio"/> 90 days
	Total Asset 100:	<input type="radio"/> 1,460 days	<input type="radio"/> 30 days	<input type="radio"/> 90 days

Inflation Protection 5% Compound Increases *(required)*

Survivorship Option* No Survivorship Benefit (7 yr.) **Only available with Total Asset 50, and Total Asset 100, if both spouses apply and are issued*

Return of Premium* No After 10 years Graded (Decreasing after 65) **Only available with Total Asset 50 and Total Asset 100*

OPTIONAL RIDERS *(available for additional premium)*

Nonforfeiture Benefits <i>(Available With All Plans Above)</i>	<input type="radio"/> Yes <input type="radio"/> No
Waiver of Premium <i>(Included With All Plans Above)</i>	<input type="radio"/> Rejected
Full Daily Maximum Benefits <i>(Available With Total Asset 50 Only)</i>	<input type="radio"/> Yes <input type="radio"/> No
Monthly Home Care Maximums <i>(Based on 31 days/Available with Dollar for Dollar 100 & Total Asset 100 Only)</i>	<input type="radio"/> Yes <input type="radio"/> No
Independent & Informal Care <i>(Available with Total Asset 50 only)</i>	<input type="radio"/> Yes <input type="radio"/> No
Combined Independent, Informal & Supplementary Care <i>(Available with Dollar for Dollar 100 and Total Asset 100 Only)</i>	<input type="radio"/> Yes <input type="radio"/> No

A. MultiLife Group Number: _____ **B.** MultiLife Group Number: _____

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.** Yes No **B.** Yes No

Limited Pay Option **A.** None 10-Pay Pay-to-65* **B.** None 10-Pay Pay-to-65* **Only available for ages 55 and younger*

Quoted Premium Amount **A.** \$ _____ **B.** \$ _____

Payment Plan *(choose one)* Annual Semi-Annual Quarterly 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).
- I have reviewed the current accident and health insurance coverage of the applicant(s) and find that the indicated replacement, or the additional coverage of the type and amount applied for, is appropriate for the applicant’s needs. According to the requirements of the NYS Partnership for long term care program, I also certify that:
 - I have offered the applicant(s) the opportunity to purchase either (applicant's choice) the 1.5/3/50 or 2/2/100 basic policy coverages with minimum Partnership regulatory benefit levels without options for added premium, and
 - I have offered the applicant(s) a basic policy coverage with minimum Partnership regulatory benefit levels without options for added premium for the design the applicant(s) has chosen.

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: _____

Signature of Licensed and Appointed Insurance Producer/Agent/Representative Date

Producer Use Only. Not for Public Use or Distribution

Insurance and annuity products:	<ul style="list-style-type: none"> • Are not deposits. • May decrease in value. 	<ul style="list-style-type: none"> • Are not insured by the FDIC or any other federal government agency. • Are not guaranteed by the bank or its affiliates.
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