

Kovack Insurance Services Inc.

Long Term Care Request

Version 2013.1

Kovack Agent Name: _____ Date _____

E-mail Address: _____

Client:

1. Name: _____
2. Birthday/Age: DOB (MM/DD/YYYY) / /
3. Gender: Male Female
4. Health: Standard Preferred
5. Status: Single Married Widow
6. Tobacco Use: Non-smoker Smoker Frequency: _____
7. State of Residence: _____
8. Daily Benefit (\$100/day=\$3000/month): \$_____
9. Inflation Rider: 2% 3% 4% 5%
10. Length of Benefits: 3 yrs 4 yrs 6 yrs lifetime
11. Ever declined for Long Term Care? YES NO Reason: _____
12. Additional Comments:

Return to Insurance@kovacksecurities.com