

Please email completed form to info@westlandinc.com

Advisor Data

Today's Date: _____ Appointment Date: _____

Advisor Name _____ Phone _____ Email _____

Quote requested by: _____ Phone _____ Email _____

Client Data

Spouse / Companion Data

Name:	Age:	Sex: M	F	Name:	Age:	Sex: M	F
DOB:	Height:	Weight:		DOB:	Height:	Weight:	
Residence State:	App Signature	State:		Residence State:	App Signature:		
Married	Single	Domestic Partner		If domestic partner, how long?		Business Owner?	
If Yes, Business Type:	C-Corp	S-Corp	Professional Corp	LLC/LLP		Self Employed	

Choose Carriers

Genworth MedAmerica John Hancock Mutual of Omaha LifeSecure Transamerica LTCIP Choose

Long-Term Care Benefits Choose Benefits or Target Annual Premium \$ _____					Additional Notes:
Benefit Amount	Home Health Care	Benefit Period	Inflation Protection	Additional Riders	
\$ _____	% _____	2 Year	GPO	Shared Care / Shared Benefit	
Daily		3 Year	5% Simple	Return of Premium	
Monthly	Elimination Period	4 Year	3% or CPI Compound	0-day Home Elimination Period	
	# of days _____	5 Year	4% Compound	Survivorship	
	_____ Calendar Days	6 Year	5% Compound	Restoration of Benefits	
Partnership Plan Requested: Yes No					

Underwriting Information

Client: Preferred Standard

Spouse / Companion: Preferred Standard

Tobacco use last 5 yrs	Yes No	Quit date:	Yes No	Quit date:
Health Conditions & Diagnosis Dates				
Medications—dosage, date started, reason for taking				
Hospitalizations in the last 5 yrs—reasons & dates				

Internal note: