WESTLAND
FINANCIAL SERVICES INC

Asset Based Long Term Care Quote Request

Please fax request to (888) 238-8154
or email info@westlandinc.com

Client Information: **JOINT POLICY: ☐ Yes ☐ No**

Name of Client:_____ Resident State:_____

DOB:_____ Gender: ☐ Female ☐ Male Smoker Status: ☐ Smoker ☐ Non-Smoker

Name of Spouse/Client #2:_____ Resident State:_____

DOB:_____ Gender: ☐ Female ☐ Male Smoker Status: ☐ Smoker ☐ Non-Smoker

Medical History

Please List Any Medications and/or Health History:

Illustration Information

Answer One of the Following Three (3) Options:
Monthly Benefit Amount: $_____ Premium: $_____ Death Benefit: $_____
Premium:

☐ Qualified ☐ Non-Qualified
Premium Duration:

☐ Single Premium ☐ Flex Premium If Flex, List Number of Years: _____
Long Term Care Benefit Options:

LTC Rider: ☐ 2% ☐ 3% ☐ 4% **LTC Continuation Rider:** ☐ Yes ☐ No

Agent Contact Information

Name:_____ State:_____

Phone: (____)_____ Fax: (____)_____

Email:_____