



Bultman Financial Services, Inc.
13625 Bishops Dr., Suite 100, Brookfield, WI 53005
Fax: 262-782-1454 Email: customerservice@bultmanfinancial.com

Fax , Mail or Email for a Long Term Care Quote and Consultation

Your Name: Date of Birth:
Spouse Name: Date of Birth:
Address:
City: State: Zip Code:
Home Phone: Office Phone: Fax:
Email:

***Completion of this form does not constitute an insurance contract, but merely a request for information.

Health Information (All information provided is confidential. The more you provide, the more helpful we can be.)

Your Height: Weight: Spouse Height: Weight:
Have you or your spouse smoked within the past three years? You: Yes No Spouse: Yes No

(Check all that apply.) Have you or your spouse been treated for:

- Heart trouble Diabetes Cancer TIA Stroke Multiple Sclerosis
Parkinson's Osteoporosis Arthritis Tuberculosis Alcoholism Drug Addiction
Depression Mental Illness Memory Loss Emphysema AIDS Liver Disease

Please explain anything you checked:

Do you or your spouse have difficulties performing activities of daily living (dressing, bathing, toileting, transferring, continence) or either of you use a wheelchair, oxygen, quad cane, catheter, walker?

Please explain anything you checked:

Current medication you use:

Current medication spouse uses:

Please explain additional medical conditions treated and surgeries or hospitalizations in the past five years or pending surgeries for you or your spouse:

I would like to meet with someone: Yes No (If yes, an insurance agent will contact you.)

Do you have any existing Disability Insurance? Yes No Company Name:

If so, what is the Monthly Benefit: Elimination Period: Benefit Period:

Group Coverage Individual Coverage What is your gross annual income?

Please me a quote.