

# Long Term Care Insurance – Request for Information

5-858W

Sponsored by the New York County Medical Society  
Please complete and fax to Marsh at: 213-346-5946

## Member Information:

Member Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: (\_\_\_\_\_) \_\_\_\_\_  
Fax: (\_\_\_\_\_) \_\_\_\_\_  
E-Mail Address: \_\_\_\_\_

## Please send me information:

Benefit Amount:..... \$100/day ..... \$150/day ..... \$200/day ..... Other: \_\_\_\_\_  
(up to \$10,000/month)

Elimination Period:..... 20 days ..... 30 days ..... 45 days ..... 60 days ..... 90 days ..... 180 days

Benefit Period: ..... 3 years ..... 5 years ..... Lifetime ..... Other: \_\_\_\_\_

Cost of Living Adjustment: ..... 5% Simple..... 5% Compound

Limited Payment Option: ..... 10-Pay..... Paid-up at 65

Group Policy for Physicians only? ..... Yes .....Number of Physicians: \_\_\_\_\_

Type of Business: ..... C-Corp..... PC ..... LLP ..... LLC ..... S-Corp

Member's Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Spouse's Date of Birth (if to be insured): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Please call me to schedule an appointment. Phone # (\_\_\_\_\_) \_\_\_\_\_

## Additionally, please send me information about these sponsored insurance programs:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Medical, including<br>High Deductible Health Plans for<br>Health Savings Accounts | <input type="checkbox"/> Long Term Disability<br><input type="checkbox"/> Business Overhead Expense<br><input type="checkbox"/> Term Life | <input type="checkbox"/> Catastrophe Major Medical<br><input type="checkbox"/> Accidental Death &<br>Dismemberment |
|--|---|--|

Sponsored by:



Administered by:

# MARSH

 MARSH MERCER KROLL  
GUY CARPENTER OLIVER WYMAN

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