

Long Term Care Insurance – Request for Information

2-857W

Sponsored by the New York City Bar Association
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 Attorneys only? YesNumber of Attorneys: _____

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

Sponsored by:



Administered by:

MARSH

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