



Long-Term Care Evaluation Worksheet

Personal and Residence Information		
	Individual	Spouse
Name		
Date of Birth		
Address		
City, State, Zip Code		
Home Phone Number		
Cell Phone Number		
Email Address		

Long Term Care Planning Concerns
What are your biggest concerns about planning for your health care as you age?
<input type="checkbox"/> Exhausting my assets and/or income to pay for needed health care.
<input type="checkbox"/> Becoming a burden to my family and/or friends to help care for me.
<input type="checkbox"/> Maintaining control over my health care decisions.
<input type="checkbox"/> Keeping my dignity in the event I need extended care.
<input type="checkbox"/> Other: _____

Current Long Term Care Coverage		
	Individual	Spouse
Company		
Monthly Benefit		
Elimination Period		
Benefit Period		
Inflation Rate		
Optional Benefits / Riders		
Annual Premium		

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