

Fax: 973-366-0837



	GOOD L
E-mail: aaron.e@ica-icb.com	INSURANCE ASSO

Agent Name/Resident State:			Phone:				
Fax	Mail	E-mail	То:				
Client Name/Resident	dent State:		M/F?	_DOB/Age:	HT/WT:		
Have you ever use	ed tobacco?	Yes	No	When was	the last time?		
Smoker Standard	Standard/Sele	ect Preferred					
Married Single Domestic Partner (living together for 5 years)							
Spouse Name:		M/F?	DOB/Age:		HT/WT:		
Have you ever use	ed tobacco?	Yes	No	When was	the last time?		
Smoker Standard Standard/Select Preferred							
Select Carriers:							
Genworth John Hancock Mutual of Omaha Transamerica MedAmerica							
If NY, IN, CT or CA, would you like a Partnership Quote (additional certification required)? Yes No							
Benefit Amount: Monthly Daily \$							
Benefit Period:	2yrs 3yrs	4yrs	5yrs 6yrs	8yrs 10yrs			
Elimination Period: 30 Days 60 Days 90 Days 180 Days 365 Days							
Inflation Protectio	n: Compound	1: 3% 49	% 5% 5	Step-Rated (Trans only)	3% 5%		
	FPO/GPO	CPI 5%	Simple No	ne Other:			
Home Care Option	ns: 50%	75% 100%					
Optional Riders:	Waiver of HH	C Elimination	Shared Care	Return of Premium	Nonforfeiture		
	Survivorship	Restoration of	Benefits Oth	er			
Payment Options:	Annual	Semi-Annual	Quarterly M	Ionthly			
Cl	ient Health Inform	ation:		Spouse	Health Information:		
*Please note benefits and underwriting requirements will vary by carrier. Please contact us for more information.							
Ţ	Date:	Propos	al Needed by				