The Insurance Group tig

ICB 30 YEARS
EXPERTS IN THE CRITICAL ART OF LTC PLANNING

E-mail to: info@ica-icb.com

CMG Proposal Request Form

Agent Name/Resident State:_____Phone:_____

☐ Fax ☐ Mail ☐ E-mail To:_____

Client Name/Resident State:_____M/F?_____DOB/Age:_____HT/WT:_____

Have you ever used tobacco? ☐ Yes ☐ No When was the last time? _____

☐ Smoker Standard ☐ Standard/Select ☐ Preferred

☐ Married ☐ Single ☐ Domestic Partner (living together for 5 years)

Spouse Name:_____M/F?_____DOB/Age:_____HT/WT:_____

Have you ever used 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 Protection: ☐ Compound: ☐ 3% ☐ 4% ☐ 5% ☐ Step-Rated (Trans only): ☐ 3% ☐ 5%

☐ FPO/GPO ☐ CPI ☐ 5% Simple ☐ None Other:_____

Home Care Options: ☐ 50% ☐ 75% ☐ 100%

Optional Riders: ☐ Waiver of HHC Elimination ☐ Shared Care ☐ Return of Premium ☐ Nonforfeiture

☐ Survivorship ☐ Restoration of Benefits ☐ Other

Payment Options: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

Client Health Information:

Spouse Health Information:

***Please note benefits and underwriting requirements will vary by carrier. Please contact us for more information.**

Date:_____ Proposal Needed by:_____ ICB Fax: 973-361-0047