

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



Individual Commercial Brokerage, Inc.
CMG Proposal Request Form

Agent Name/Resident State: _____ Phone: _____

Fax _____ Mail _____ E-mail _____ To: _____

Client Name/Resident State: _____ Client DOB/Age: _____ HT/WT: _____

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

Tobacco use in the last 5 years? Yes No Standard Health Preferred Health

Spouse Name: _____ Spouse DOB/Age: _____ HT/WT: _____

Tobacco use in the last 5 years? Yes No Standard Health Preferred Health

Select Carriers:

Genworth John Hancock Mutual of Omaha Prudential ICB Recommendation

If NY, IN, CT, or CA, would you like a Partnership Quote: Yes No

Benefit Amount: Monthly Daily \$ _____

Benefit Period: 2 yrs (when avail.) 3yrs 4yrs 5yrs 6yrs 7yrs 10yrs Lifetime (when avail.)

Elimination Period: 30/45 Days 60 Days 90 Days 180 Days Other: _____

Inflation Protection: 5% Compound None 3% Compound Other: _____ 5% Simple FPO/GPO CPI

Home Care Options: None 50% 75% 100%

Optional Riders: Waiver of HHC Elimination Nonforfeiture Restoration of Benefits Shared Care Survivorship Other: _____ Return of Premium

Payment Options: Annual Semi-Annual Qtly Monthly Limited Pay: 10-pay Pay to 65 Other: _____

Client Health Information: (continue on next page if needed)

Spouse Health Information:

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