



Product Proposal/Illustration Request Form (Fax to 518.371.6131)

Life: Face Amount _____ Term ____ Yrs.? Trad. UL ____ Guar. No Lapse UL ____ IUL ____ WL ____ Waiver? <u>Y/N</u> Level/Increasing Death Benefit? _____ Riders? _____ Solve for Value? _____ 1035 Exchange? Y/N If Y, amount? _____ LTC/Chronic Rider? Y/N	
LTCI: Partnership: Y/N - Daily/Mo. Benefit _____ Benefit Period: ____ Yrs. - Elim. Period 30-90 Days Inflation %, if Desired _____ or GPO? _____ Home Care % _____ Riders _____	
Linked Life/Annuity (circle): Single/Annual Premium Amount _____ 1035 Exchange? Y/N LTC Daily/Monthly Benefit Desired _____ No. Of Years _____ Inflation? Y/N	
DI: Occupation _____ Specific Duties _____ Own Business? If so, Classification – Sole Prop ____ S-Corp. ____ LLC ____ C-Corp ____ Mon./Ann. Income (after expenses)? \$ _____ Monthly DI Benefit Desired \$ _____ (or Max) Waiting Period – 60-90-120-180-365-730- ____ days Benefit period – 2yrs.-5 yrs.-to Age 65-to Age 67 _____ Disability Coverage (Individual or Group) Inforce? Details _____	
Annuity: Immediate-SPIA/Deferred (circle) - Desposit Amount? _____ Tax Qualified? _____ Deferred: Traditional/Indexed (circle) SPIA: Income Desired? _____ Mode: Monthly/Annually (circle) SPIA: Life Only Y/N-Period Certain (# years) _____ Installment Refund Y/N – Survivor Bene.%-100/66/50	
Other Product/Rider Requests:	
<u>Producer Name:</u>	Phone:
Fax:	Email:
State of Application:	Firm Affiliation:
<u>Client Name:</u> M/F	<u>Spouse/Partner Name:</u> M/F
D.O.B. or Age:	D.O.B. or Age:
Tobacco Use (last 24 Months): Y/N	Tobacco Use (last 24 Months): Y/N
Prescriptions (Dosage/Frequency)?	Prescriptions (Dosage/Frequency)?
Health Conditions?	Health Conditions?

Our Policy is Taking Care of You
 Long-Term Care | Life | Disability | Annuities | Medicare | Benefits

Affiliate Company of



Need Help? 800.695.8224:
Life-Option 3
LTC-Option 2; Linked/Life
- x100/126
Linked/Annuity - x109
DI - x132