QUOTE REQUEST FORM: PLEASE FAX TO MOWERY ASSOCIATES

FAX: 717-761-5029 ---------- PHONE: 800-382-1352

Date: _____ Need by Date: _____ Faxed/Mailed/Both/E-mailed – SEND BROCHURES & APPS

Agent Name: _____ DOB: _____

Address:_____

Phone: _____Fax: _____ Resident State: _____

E-Mail Address: _____ Soc.Sec. # _____

Please circle carrier(s) requested (Maximum of 2):

Genworth (Privileged Choice Flex, Total Living Coverage), **MedAmerica** (Simplicity ii, Flex Care, Transitions), **Mutual of Omaha** (Mutual Care 3 or 5, Mutual Care-My Way) **United of Omaha** (Assured Solutions Gold, Cash First), **Transamerica** (Trans Care Options II), **Hancock** (Custom III – Enhanced, Core Care), **One America/State Life, Mass Mutual** (Signature 500) **Lincoln** (Moneyguard Plus)

Riders: Waiver of HHC Elimination, Restoration of Benefits, Survivorship, Return of Premium, Shared Care, Cash Benefits, Indemnity, Non-Forfeiture, Flex to 85, Single Pay, 10 pay & Pay to 65

Clients Name: _____

DOB: _____ State: _____
HGT: _____ WGT: _____
Married: YES NO

Tobacco Use within Last 5 Years: YES NO

Choose Plan Design:

Daily/Monthly Benefit: _____

Elimination Period: 20 30 45 50 60 90 100 180

Benefit Period: 2, 3, 4, 5, 6, 7, 10, LIFE

Inflation Increase: 3%, 5%S, 5%C, CPI, GPO NONE

Home Health Care Percentage: 50, 75, 80, 100

MEDICAL CONDITIONS/MEDICATIONS:

_____

_____

_____

_____

_____

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