

**Request for Premium Estimate**

(For determining premium necessary for Single Premium Immediate Annuity, SA 33. Not available in all states.)

This is not an annuity application.

Products and financial services provided by  
The State Life Insurance Company  
a ONEAMERICA® company  
P.O. Box 406  
Indianapolis, IN 46206  
(800) 275-5101



**Attention! ImmediateCare is designed for people already receiving long-term care. If the proposed client does not need substantial assistance with multiple activities listed in section five, please do not submit.**

**SECTION 1 – Client Information**

Name \_\_\_\_\_ State \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex  Male  Female

If potential annuitant does not answer the questions, please indicate who is providing the information:

\_\_\_\_\_  
Why?

**SECTION 2 – Illustration Details**

Amount of Monthly Income Requested: \$ \_\_\_\_\_ or Cash Sum Available: \$ \_\_\_\_\_

(Date of First Payment: \_\_\_\_\_ )

Current Care Status:  Home Care  Assisted Living  Nursing Home

**SECTION 3 – Medical History** (check box of all that apply and briefly describe)

Stroke \_\_\_\_\_  Number \_\_\_\_\_  Onset Date \_\_\_\_\_  Paralysis \_\_\_\_\_

Heart Attack  Heart Failure  Severe Heart Condition

\_\_\_\_\_ Onset Date \_\_\_\_\_

Alzheimer’s Disease  Dementia \_\_\_\_\_ Onset Date \_\_\_\_\_

Chronic Respiratory Disorder (e.g., Bronchitis, Emphysema)  Insulin-Dependent Diabetes  Rheumatoid Arthritis

\_\_\_\_\_ Onset Date \_\_\_\_\_

Cancer, excluding Skin Cancer \_\_\_\_\_ Onset Date \_\_\_\_\_

Any additional pertinent medical information. Please explain: \_\_\_\_\_

\_\_\_\_\_

**SECTION 4 – Medications**

Yes  No Is the potential annuitant currently taking any medication? If “Yes,” please provide details in the space below.

<u>Drug Name</u>	<u>Reason for Taking</u>	<u>Drug Name</u>	<u>Reason for Taking</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**SECTION 5 – Self-Care**

Currently needs assistance or supervision excluding verbal reminder or instruction, of another person in performing the following activities:

	<u>No Assistance</u>	<u>Occasional Assistance</u> (49% of time or less)	<u>Substantial Assistance</u> (50% of time or more)	<u>Total Assistance</u>
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moving in/out of bed or chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel/Bladder Control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Currently uses any of the following (check all that apply):

- Walker
- Wheelchair
- Oxygen
- Dialysis
- Respirator
- Chairlift
- Quad Cane (4-pronged cane)
- Motorized Cart (such as a “Lark” or “Amigo”)

**SECTION 6 – Additional Information**

Briefly describe any other pertinent medical history or conditions that are not addressed in sections 3, 4 or 5.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Fax completed form to: ImmediateCare® Quote fax number (317) 713-7877

Producer Name \_\_\_\_\_ ID No. \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Please return estimate via  Fax: ( \_\_\_\_\_ ) \_\_\_\_\_ or  E-mail address: \_\_\_\_\_

Note: The single premium or monthly income amount generated by State Life from this request is an estimate only. Actual amounts, determined after medical underwriting, may be greater than or less than the estimate.

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