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

OneAmerica®

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.

Drug Name	Reason for Taking	Drug Name	Reason for Taking

SECTION 5 – Self-Care

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

	No Assistance	Occasional Assistance (49% of time or less)	Substantial Assistance (50% of time or more)	Total Assistance
Bathing	☐	☐	☐	☐
Dressing	☐	☐	☐	☐
Moving in/out of bed or chair	☐	☐	☐	☐
Toileting	☐	☐	☐	☐
Bowel/Bladder Control	☐	☐	☐	☐
Eating	☐	☐	☐	☐
Taking Medications	☐	☐	☐	☐

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.