chronovo™

Annuity Quote Referral Form

▶ REFERRAL GUIDELINES

1. Please fill out general information below
2. Email this form and any required documents to your Chronovo Case Advocate or to **info@chronovo.com**
3. Call **1 844 600 NOVO (6686)** with any questions

▶ CLAIM INFORMATION

Claimant Name: ..... Date of Birth: .....

Claim Number: ..... Date of Loss: .....

Employer / Insured: ..... Loss State: .....

▶ REFERRING ADJUSTER INFORMATION

Adjuster Name: .....

Email: ..... Telephone: .....

▶ TYPE OF ANNUITY QUOTE(S) REQUIRED

☐ **WORKERS' COMPENSATION**

○ **Medical Annuity Quote**
Include MSA / MCP / LCP / CMS Approval (If these are not available please provide a yearly average medical cost)

○ **Indemnity Annuity Quote**
Provide outstanding indemnity value (PD/LP/TD): .....

Answer one of the following:
– How much do you want to spend? .....
– How much do you want to pay over time? .....

☐ **LIABILITY QUOTE**

\+ Structure Amount (Cost): ..... \+ Upfront Cash Amount: .....

\+ Attorney Fee Amount: ..... \+ Lien Amount: .....

= Total Settlement Amount: .....

☐ **ATTORNEY FEES**

☐ **DISABILITY**

Other (Notes / Comments / Other Instructions):