



Disability Quote Request

Agent Information:

Name: _____
Phone# _____ Fax# _____
Street Address _____
City _____ State _____ ZIP _____

Client Information:

Name _____ DOB/Age _____
Sex: Male /Female Tobacco Use: Yes / No Resident State: _____ Work State: _____
Net Annual Income: Salary: \$ _____ Bonus (2 yr. avg.) \$ _____
Occupation _____
Job Description/Duties _____
Business Owner: Yes / No If Yes: C Corp. / S-Corp. / LLC / Partnership / Sole Proprietor
Number of Employees: Full Time: _____ Part Time: _____ Years in Business: _____
Group DI Inforce: _____ Taxable Benefits: Y / N Carrier _____
Indiv DI Inforce: _____ Taxable Benefits: Y / N Carrier _____
Medical Conditions _____
Medicine (Name, Dosage) _____

Individual Policy Information:

Monthly Benefit: Base\$ _____ SISS\$ _____ Retirement\$ _____
Premium Payer: Employee/ Employer Waiting Period: 7 days/ 30 / 60 / 90 / 180 / 365
Benefit Period: 3 mos / 6 mos / 1 yr / 2 yrs / 5 yrs / age 65 / age 67 / age 70 / Lifetime
Riders: Residual / Cola / Guar. Insurability / CAT / Transitional Your Occ / Own Occ
Other Information _____

Business Overhead / Buy Sell / Business Protector

Ownership %: _____ Monthly Expenses \$ _____
Business Value \$ _____ Loan Amount \$ _____

BOE

DBS

Benefit: Monthly: \$ _____ Lump Sum: \$ _____ Monthly: \$ _____
Waiting Period: 30 days / 60 days / 90 days 365 days / 540 days / 730 days
Benefit Period: 12 mos / 18 mos / 24 mos 2 yrs / 3 yrs / 5 yrs / Lump Sum