Disability Proposal Request Form

Broker Information

Today's Date:

Broker's Name (as name should appear on proposal): Affiliation:

Address: Cell Phone: Office Phone:

City: State: ZIP:

Email to: Email copy to:

Client Information

Client Name: DOB:

Sex: ❍M ❍F Tobacco User: ❍Yes ❍No State:

Gross Annual Income (W-2): $ **- OR -** Net Annual Income (Self-Employed): $ Pension Income: $

Occupation: Work at Home: ❍Yes ❍No % of time:

Occupational Duties:

Company: ❍Business Owner / Self-Employed ❍C-corp Number of Employees: Years in Business:

Government Employee: ❍Yes ❍No Years of Government Employment: ❍Federal ❍State ❍County ❍City

Group LTD in Force: ❍Yes ❍No Monthly Amount: $ ❍60% ❍67% Employer Paid: ❍Yes ❍No

Individual Coverage in Force: ❍Yes ❍No Monthly Amount: $ To Remain in Force: ❍Yes ❍No Carrier:

Medical Issues or Other Comments:

Individual Disability Policy

Who Will Pay the Premium? ❍Employer ❍Employee Monthly Benefits: $ Client's Monthly Budget: $

Elimination Period: ❍30 ❍60 ❍90 ❍180 ❍365 Benefit Period: ❍2 Yrs. ❍5 Yrs. ❍To age 65 ❍66/67 ❍70

Benefit Riders: ❍SSIB __________ ❍Residual Benefits ❍COLA ❍Non-cancelable ❍Return of Premium ❍CAT __________
❍Own-Occ. ❍Future Purchase Option ❍Automatic Increase Benefit (AIB) ❍Student Loan ❍DIS Recommendation ❍No Riders

Would you like a long-term care insurance quote as well? ❍Yes ❍No Critical Illness Quote? ❍Yes ❍No

Overhead Expense Policy

Monthly Benefit: $ Elimination Period: ❍30 ❍60 ❍90 Benefit Period: ❍12 mos. ❍18 mos. ❍24 mos.

Benefit Riders: ❍Residual Benefits ❍Future Purchase Option