

Disability Proposal Request

Agent Information

Agent: _____

Today's Date: _____

Office: _____

Phone: _____

Contact: _____

Fax: _____

E-mail: _____

Client Information

Prospect Name: _____

State of Residence: _____

Age or DOB: _____

Male Female

Occupation: _____

Tobacco Use? Yes No

Specific Duties: _____

Who is paying the premium?

Income: _____

Employee Employer

Is there other coverage in-force? Yes No

Group LTD \$ _____ Individual DI \$ _____

Medical Conditions: _____

Benefits to Quote

DISABILITY INSURANCE

Monthly Benefit: \$ _____ Or Maximum Available

Elimination Period: 30 days 60 days 90 days 180 days 365 days 730 days

Benefit Period: 2 years 5 years Age 65 Age 67 Lifetime

Optional Benefits: Own Occ Residual COLA Future Purchase Options Social Security Offset

BUSINESS OVERHEAD EXPENSE

Monthly Benefit: \$ _____

Elimination Period: 30 days 60 days 90 days

Benefit Period: 12 months 18 months 24 months

Optional Benefits: Residual Future Purchase Option Salary of Replacement

DISABILITY BUY-OUT

Monthly Benefit: \$ _____ Or Lump Sum Benefit: \$ _____

Elimination Period: 12 months 18 months 24 months

Benefit Period: Lump Sum 18 months 24 months 36 months 60 months

Total Coverage Desired: \$ _____

Comments: _____
