Disability Insurance Proposal Request

Date _____ **Needed By** _____

BROKER _____ Phone _____

Address _____ Fax _____

Client's Resident State _____ E-Mail _____

CLIENT _____ DOB / Age _____ M F

Occupation _____ Tobacco ***Use*** No Yes – Type _____

List Job Duties And % Of Time Spent On Each Duty *(Be Exact)* _____

_____

Current Salary (NET earnings if self-employed) _____ Add'l / Unearned Income _____

EXISTING DISABILITY INSURANCE

Group / Individual Prem Paid by Employer / Employee

Benefit Amt / % Of Income _____ Monthly Cap _____

Elimination Period _____ Benefit Period _____

BENEFIT OPTIONS – INDIVIDUAL

Basic Amount _____ SIS _____ Total Mo Benefit _____

Elimination Period 30 Day 60 Day 90 Day 180 Day 365 Day

Benefit Period *(may be limited to occ class)* 2 Yr 5 Yr To Age 65, 67, 70

BENEFIT OPTIONS – OVERHEAD EXPENSE

Monthly Expenses _____

Elimination Period 30 Day 60 Day 90 Day

Benefit Factor 12 Times 18 Times 24 Times

BENEFIT OPTIONS – DI BUY-OUT

Business Value _____ % Ownership _____

Elimination Period 365 Day 540 Day 730 Day

Payment Method Lump Sum Monthly Installments Combination

ADDITIONAL RIDERS *(not all riders available to all occ classes)*

Cost Of Living	Residual Disability	Extended Benefit Period
Benefit Increase	Return To Work	Regular Occupation

Special Instructions / Goals To Meet _____

_____

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