Disability Income Fact Finder

Name _____ M F DOB _____
State of Residence _____

Tobacco Use: Cigarette___Smokeless___Cigar Only___None___Last Used_____

Health: _____

Occupation _____ Class _____
Duties _____
_____

Employer _____
Time in this Occ _____ Prior Occ & Time _____

Earnings: Salary / Mo. _____ Education_____
Unearned Income (dividends, rents, interest, etc.) _____

Self Employed: Mo. Income (net after deduction of expenses) _____

Current Disability Coverage: Group Mo Benefit & Max/Mo: _____
Individual Mo Benefit: _____

Premium will be paid by: Insured _____ Employer _____

Business DI -

Business: Sole Prop___Ptnrshp___S Corp___C Corp___PC___LLC__Other _____

Other Key employees or Co-Owners & Jobs _____
_____
_____

Average Monthly Business Expenses _____

Is there a Buy / Sell agreement between owners _____

Comments & Other Information _____
_____

Broker's Name
Address

Phone
Fax
Email

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