
# Disability Income Insurance Quote Request Form

Please e-mail to jon@wardbrokerage.com or fax to: (860) 394-4948

**Broker Information**

Date_____ Proposal to be: ___faxed____mailed____e-mailed

Name:_____

Company:_____

Address:_____

e-mail:_____

Phone:_____Fax:_____

**Client Information**

Client Name: _____

D.O.B._____ Sex: _____M_____F Smoker: _____Y_____N

Occupation: _____ Income:_____

Specific Job Duties/Specialty: _____

Business Owner: ____Y ____N Number of employees: _____

# Years in business____

Premium: ___EE pay ____ER pay State of issue _____

Current coverage in force: Individual monthly amount $_____

Current carrier of in force coverage: _____Replace: ____Y _____N

Group coverage benefit $ _____

## Quote Information

**Individual**

Monthly Benefit $ _____ Elimination Period: ___60 ___90 ____180 ____365

Benefit Period: _____2 years _____5 years _____ to age 65/67

**Benefit Options**

___Residual _____COLA 3% or 6% Future Increase Option $ _____

**Business Overhead**

Monthly Benefit $ _____

Elimination Period: ___ 30 days _____60 days ____ 90 days

Benefit Period: ____ 12 months _____ 18 months ____ 24 months

**Disability Buy-Out**

Elimination Period:___ 12 mos. ____ 18 mos _____24 mos

Funding method: ___ monthly ___lump sum ___combination

Valuation of the Business:_____

Number of Owners:_____

Business type: service or commercial

**Multi-Life**

Please call