

# Disability Insurance Proposal Request

## Producer Information:

Producer Name: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

How should we return the illustration?  Producer Email: \_\_\_\_\_  Fax \_\_\_\_\_

## Client Information

Prospect Name: \_\_\_\_\_  Male  Female

Date of Birth: \_\_\_\_\_ State of Residence: \_\_\_\_\_ State written in: \_\_\_\_\_

Occupation (Be specific): \_\_\_\_\_ Tobacco use?  Yes  No

Specific Duties (Time spent doing each): \_\_\_\_\_

Who is paying the premium?  Employee  Employer Salary or Net Income: \_\_\_\_\_

Is Client:  Salary Employee?  Sole Prop?  LLC/Partnership?  S-Corp Owner?  C-Corp Owner?

If business owner, length of time owned? \_\_\_\_\_ Number of employees: \_\_\_\_\_

Is there other coverage in force?  Yes  No Group LTD \$ \_\_\_\_\_ Individual DI \$ \_\_\_\_\_

Medical Conditions: \_\_\_\_\_

Carrier preference: \_\_\_\_\_

## 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  Social Security Rider  Show All

### Business Overhead Expense (BOE)

Monthly Benefit: \$ \_\_\_\_\_ (Only expenses that would continue during disability)

Elimination Period:  30 days  60 days  90 days

Benefit Period:  12 months  18 months  24 months

Optional Benefits:  Residual  Future Purchase  Salary of Replacement  Show All

### Disability Buy-Out (DBO)

Monthly Benefit: \$ \_\_\_\_\_ or Lump Sum Benefit: \$ \_\_\_\_\_

Elimination Period:  12 months  18 months  24 months

Benefit Period:  Lump Sum  24 months  36 months  60 months

Total Coverage Desired: \$ \_\_\_\_\_

Comments: \_\_\_\_\_

Do you need contracting for this carrier?  Yes  No Do you need an application sent?  Yes  No