Disability Income Proposal Request Form

Agent Name: _____ Phone Number: _____

Email Address: _____ Fax Number: _____

Client Name: _____ Gender: _____ DOB: _____ Issue State: _____

Tobacco Use: ☐ Never used ☐ Cigarettes ☐ Other tobacco ☐ Former user Date of last use: _____

Neck or back disorders: ☐ Yes ☐ No

Depression, anxiety or other mental disorders: ☐ Yes ☐ No

Diabetes: ☐ Yes ☐ No

Sleep Apnea: ☐ Yes ☐ No

Cardiac conditions: ☐ Yes ☐ No

Cancer: ☐ Yes ☐ No

Other known health conditions for which lengthy treatment was needed: _____

Height: _____ Weight: _____ Annual Income: _____

Occupation: _____ Time at current employer: _____

Coverage Amout Requested: _____

Benefit Period: ☐ 2 Yr ☐ 5 Yr ☐ To age 65 ☐ To age 70

Waiting Period: ☐ 60 Days ☐ 90 Days ☐ 180 Days ☐ 365 Days

Optional Riders: ***(Not all riders available with all plans)***

COLA: ☐ 3% ☐ 6%

Residual Disability Benefit: ☐ Yes ☐ No

Extended Total Disability Benefit: ☐ 50 ☐ 75 ☐ 100 Benefit Factor

Catastrophic Disability Benefit: ☐ Maximum ☐ Specified Amount: _____

Desired Elimination Period: ☐ 30 day ☐ 60 day ☐ 90 day ☐ 180 day ☐ 365 day

Desired Benefit Period: ☐ 2 Yr ☐ 5 Yr ☐ To age 65 ☐ To age 70

Business Overhead Expense

Occ Class _____ Monthly Benefit _____

Benefit Period: ☐ 12 Months ☐ 18 Months ☐ 24 Months

Waiting Period: ☐ 30 day ☐ 60 day ☐ 90 day

Options Benefits: ☐ Premium Refund ☐ Future Guarantee Insurability Benefit

Existing group disability insurance: Monthly amount or percent of income: _____

Existing indvidual disabilty insurance: Monthly amount $ _____

Will it be replaced? ☐ Yes ☐ No

Fax this request to 781.449.7694
Attn: Derek Wakefield

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