Disability Income Proposal Request Form

Agent's Name: _____ Phone Number: _____

Email Address: _____ Fax Number: _____

Client's Name: _____ ☐ M ☐ F DOB: _____ Issue State: _____

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

Neck or back disorders: ☐ Yes ☐ No
Diabetes: ☐ Yes ☐ No
Cardiac conditions: ☐ Yes ☐ No
Depression, anxiety or other mental disorders: ☐ Yes ☐ No
Sleep Apnea: ☐ Yes ☐ No
Cancer: ☐ Yes ☐ No

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

Height: _____Weight: _____ Annual Income: _____

Occupation: _____ Length of employment at current employer: _____

Coverage Requested: _____

Benefit Period: ☐ 2 Years ☐ 5 Years ☐ To age 65 ☐ To age 70
Waiting Period: ☐ 60 Days ☐ 90 Days ☐ 180 Days ☐ 365 Days

Optional Riders: ***(Not all riders are 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 Specific Amount: _____
Desired Elimination Period: ☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ 180 Days ☐ 365 Days
Desired Benefit Period: ☐ 2 Years ☐ 5 Years ☐ To age 65 ☐ To age 70

Business Overhead Expense:

Occ Class: _____ Monthly Benefit: _____
Benefit Period: ☐ 12 Months ☐ 18 Months ☐ 24 Months
Waiting Period: ☐ 30 Days ☐ 60 Days ☐ 90 Days
Options Benefits: ☐ Premium Refund ☐ Future Guarantee Unsurability Benefit

Existing Group Disability Insurance: Monthly $ amount or % of income: _____

Existing Individual Disability Insurance: Monthly $ amount: _____

Will it be replaced? ☐ Yes ☐ No

Please fax to 781.449.7694 Attn: DI Specialist

460 Hillside Avenue • Needham, MA 02494
T 781.449.6800 • F 781.449.7694 • www.faiu.com

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