

Disability Insurance Proposal Request

Date Submitted: _____ Date Required: _____

Name of Prospect: _____ Birth date: _____

State: _____ Sex: Male Female Height/Weight: _____

Tobacco Use: No Yes

Health Issues/Details/Medication(s): _____

Gross Monthly Income: \$ _____ Monthly Benefit Requested: \$ _____

Occupation & Job Duties: _____

Mode of Premium: Annual Semi-Annual Quarterly Monthly Bank Draft

Do they currently have a policy in place or participate in an employer-sponsored plan? _____

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

Benefit Period: 1 year 2 year 5 year To Age 65

Policy Type:

Personal:

Simplified Fully Underwritten

Riders:

Return of Premium Critical Illness Benefit Retroactive Injury Benefit Supplemental Disability

Automatic Benefit Increase Non-Cancellable 5-yr Own Occupation Catastrophic Disability

Residual Benefit Hospital Benefit Guaranteed Insurability.

Business Overhead Expense

Any other instructions or details: _____

Printed Name of Agent: _____ Phone: _____

Address: _____ Fax: _____

Email: _____