

Producer Information

Name _____ E-Mail _____ Fax _____

Date: _____ Need by: _____ State: _____ Send via: E-mail Fax Mail

Insured Information

Name _____ DOB _____ State _____ Sex Male Female

Height _____ Weight _____ Tobacco Use Current/Type _____ Former/Type _____ Date Quit _____ Never

Occupation _____ Professional Designations _____ Length of time in current occupation _____

Duties of Occupation _____ (if multiple duties break down by percentage)

Self Employed Yes No - If Yes Number of employees _____ Type of Business C Corp S Corp Sole Prop

Annual Adjusted Gross Income (AGI) _____ Annual Unearned Income _____ Net Worth _____

Medications – List Name & Dosage of Medications and Condition Being Treated with the Medication:

Medical Conditions or Hospitalizations in Last 10 Years (include any treatment for back, joint, muscular, depression or anxiety)

Policy Quote Information

Monthly Benefit Amount: _____ Quote Maximum Benefit

Benefit Period: 2 Year 5 Year Age 65 Age 67 Age 70 Lifetime

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

Riders: Residual COLA Future Purchase Option Your Occupation Period _____ Catastrophic Disability

Existing Coverage Information

Coverage: NONE Group DI Individual - Elimination Period: _____ Monthly Benefit: _____
Benefit Period: _____ Company _____ Replacing Coverage? Yes No