NORTHEAST BROKERAGE

Life | Annuity | LTC | DI

Disability Income Illustration Request Form

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**

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