

Disability Income Illustration Request Form

Producer Information:

Name: _____ Email: _____ Phone: _____

Date needed by: _____ State: _____

Insured Information:

Name: _____ Date of Birth: _____ Male Female State: _____

Height: _____ weight: _____ Blood Pressure: _____ Cholesterol: _____

License number: _____ License expiration: _____

Occupation: _____ Professional designation: _____ Length at occupation: _____

Duties of occupation: _____ (If multiple break down by %)

Annual Adjusted Gross Income: _____ Annual unearned income: _____ Net worth: _____

Current coverage in force: Life Disability Long term care Annuity

Insured medical information:

Medications- List Name & dosage of medication 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 max amount

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

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Insured medical information continued:

1. Heart conditions: Coronary artery, valve, heart muscle, high blood pressure, rhythm disorders? Yes No
2. Nicotine Use: Currently using- Type _____ Formally used- Type _____ - Date quite _____ Never used
3. Peripheral vascular disease: Carotid artery stenosis, blockage of leg arteries? Aneurysms, other? Yes No
4. Cancer or Tumors: Organ involved: _____ Tumor type: _____ Stage/Grade: _____ Not applicable
5. Mental health disorders: anxiety, depression, ADHD, bipolar, panic disorders, PTSD, other? Yes No
6. Lung disorders: asthma, sleep apnea, chronic bronchitis, emphysema, sarcoidosis, pulmonary fibrosis, other? Yes No
7. Brain disorders: stroke, TIA, multiple sclerosis, seizures, dementia, neuropathy, global amnesia, other? Yes No
8. Diabetes: Type-I Type-II Treatment _____ Diagnosis date: _____ Largest HgA1c _____ Not applicable
9. Muscles disorders: myasthenia Gravis, muscular dystrophy, polymyositis, dermatomyositis's, other?
10. Blood disorders: Anemia-type _____ clotting disorders-type _____ other? _____ Not applicable
11. Rheumatoid arthritis, Grave's disease, thyroiditis? Yes No
12. Systematic lupus, Ankylosing spondylitis, chronic fatigue syndrome? Yes No
13. Kidney inflammation, protein or microalbumin in urine? Pituitary disorders, Adrenal disorders? Other? Yes No
14. Liver disorders- hepatitis, fatty liver, abnormal liver function tests, other? Pancreatitis? Other? Yes No
15. Diverticulosis, weight-loss surgery, esophageal disorders, GERD, ulcerative colitis, Crohn's disease, other? Yes No
16. Arteritis, vasculitis, chronic pain syndrome, bone or joint disorders, ear, nose and throat disorders? Yes No
17. Substance use: Type: _____ date of any rehabilitation: _____ Relapse date: _____ Not applicable
18. Any condition not listed?

Please explain any information to which you answered yes or to which more information should be provided:

Existing Coverage Information:

Coverage: None Group Disability Individual

Elimination period: _____ Monthly period: _____ Benefit period: _____ Company: _____

Replacing Coverage? Yes No