NORTHEAST BROKERAGE

Life | Annuity | LTC | DI

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: ____________________ Smoker?

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

Northeast Brokerage
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Insured medical information continued:

1. Heart conditions: Coronary artery, valve, heart muscle, high blood pressure, rhythm disorders? ☐ Yes ☐ No
2. Tobacco/ Maryjuana: Yes No Date last used, type, frequency, method: ___________________________________
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, dermatomycosis'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

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