

INDIVIDUAL DISABILITY PROPOSAL REQUEST

Agent Name:		Date:
Company:		Email:
Address:		Phone:
City/State:	Zip:	Fax:

PROPOSED INSURED INFORMATION

Client Name: _____	DOB: _____	Non-Smoker: How Long: _____
	M / F	Smoker: Cigarettes / Cigar / Pipe / Chew _____
Income: Annual / Monthly \$ _____		Std / Substd _____
Occupation: _____		State Disability Coverage: Y / N
Specific Duties: _____		Existing Group LTD Coverage: Y / N
Specialty if M.D.: _____		If yes, Monthly Benefit \$ _____
		Existing Individual Coverage: Y / N
		If yes, Monthly Benefit \$ _____
Employee Paid or Employer Paid		

INDIVIDUAL PLAN OPTIONS

Plan Choices

<u>Standard Insurance</u>	<u>Guardian</u>	<u>Assurity</u>	<u>Union Central</u>	<u>Principal</u>
Protector+	Provider Plus	Assurity Balance	DInamic 2000	Solutions 2
5A 4A 4P 3P 3A	6 6M 5 5M	4A, 3A, 2A, 1A	5AP 5A 4A 4M	5A 5AM 4A 4AM
2A A B	4 4M 3 3M		3AP 3A 2A	3A 3AM 2A A
	2 2M 1 1M			
Multi-Life Discount	Y / N			
Waiting Period(s): 30 60 90 180 365 730	Benefit Period(s): 1 yr 2yrs 5yrs 10 yrs Age 65 Age 66/67			Monthly Benefit Amount(s): \$ _____
<i>Optional Riders</i>				
Supplemental Social Benefit: Y / N (Must be 365 days if W-2 employee)	60 90 180 365		Non-Cancelable:	Y / N
Monthly Benefit Amount: \$ _____			Residual Disability:	Y / N
			Fixed Cost of Living:	Y / N
			Indexed Cost of Living:	Y / N
			Future Purchase:	Y / N
			Own Occupation:	Y / N

BUSINESS PLAN OPTIONS

Business Overhead Expense:	Buy-Sell:
Waiting Period: 30, 60, 90 days	Waiting Period(s): 12 18 24 months
Benefit Period: 12 18 24 months	Benefit Period: Lump Sum or Down Payment/ Monthly – 2, 3, or 5 years
Benefit Amount: \$ _____	Benefit Amount: \$ _____
Future Purchase: Y / N Residual Disability: Y / N	Extended Benefit: Y / N Future Buy-Out: Y / N
# of employees (4 max) _____ (check guidelines)	
# of owners _____	

Confidential Personal Questionnaire for Disability Protection

AGE	30	35	40	45	50	55
Odds of Disability*	42%	41%	39%	36%	33%	27%
Average Duration**	5.1 Years	5.1 Years	6.6 Years	6.6 Years	5.6 Years	3.8 Years

*1985 CIDA Table, ** 1985 Society of Actuaries DTS Odds and length of disability 90 days or longer prior to age 65

Client Name _____

Date of Birth _____

1. If your disability were “average”, how much would it cost you in lost wages? _____ \$ _____

Disability insurance is underwritten like a health plan; May I ask some health questions?

2. Do you manage any **health conditions**? _____
3. Do you take any **medications**? _____
4. Have you ever been **injured or hurt**? _____
5. Ever had an illness like **diabetes, cancer, or heart disease**? _____
6. When was the last time you went to a **Doctor or Chiropractor**? _____
7. Have you used **tobacco products** in the last year? _____
8. Tell me what you do during “**a day at the job**”?
Do you have a **specialty**? _____
9. What are the **physical requirements and tools** you use? _____
10. Are you an **employee or self-employed**?
If **self-employed**, how long? _____
11. Do you **work from home**?
If yes, **more than 60%** of the time? _____
12. Is this the **only work** you do? _____
13. Does your **job require traveling**?
If Yes, How much? How long? _____
14. Are you eligible for any **other disability protection** at work? _____
15. Do you fly as a **pilot, race cars, scuba dive** or do **any hazardous activity**? _____
16. What do you declare to the **IRS** as your **income after business expenses**? _____