

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 / Chew/Weed _____
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>Ameritas</u>	<u>Principal</u>
Platinum Advantage	Provider Choice	AssurityBalance	DInamic Foundation	DI Solutions
5P 5A 4A 4P 3P 3A	6 6M 5 5M	Century+	6A 5A 4A 3A	5A 5AM 4A 4AM
2P 2A A B	4 4M 3 3M	4A 3A 2A 1A	2A A B	3A 3AM 2A A
	2 2M 1 1M		6M 5M 4M 3M	
Multi-Life Discount	Y / N		2M M	

Waiting Period(s): 30 60 90 180 365 730	Benefit Period(s): 1 yr 2yr 5yr 10 yr Age 65 Age 67 Age 70	Monthly Benefit Amount(s): \$ _____
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Optional Riders

Supplemental Social Benefit: Y / N	60 90 180 365	Non-Cancelable: Y / N
(Must be 365 days if W-2 employee)		Residual Disability: Y / N
Monthly Benefit Amount: \$ _____		Catastrophic Benefit: Y / N
		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. Have you used **tobacco products** in the last year? _____

6. Tell me what you do during "**a day at the job**"?
Do you have a **specialty**? _____

7. What are the **physical requirements** and **tools** you use? _____

8. Are you an **employee** or **self-employed**?
If **self-employed**, how long? _____

9. Do you **work from home**?
If yes, **more than 60%** of the time? _____

10. Is this the **only work** you do? _____

11. Does your **job require traveling**?
If Yes, How much? How long? _____

12. Are you eligible for any **other disability protection** at work? _____

13. Do you fly as a **pilot**, **race cars**, **scuba dive** or do **any hazardous activity**? _____

14. What do you declare to the **IRS** as your **income after business expenses**? _____

