Disability Insurance Proposal Request

Agent Information

Name _____ Date _____

Phone _____ Email _____

Client Information

Age _____

Gender _____

State _____

Height _____

Weight _____

Tobacco

- ☐ None for 1yr or More
- ☐ Cigar Only - # of Years: _____
- ☐ Cigarettes, Pipe, Chew - # of Years: _____

Occupation _____ Years employed in current industry _____

Specific Job Duties _____

Hours per Week _____ Percentage of Ownership _____

Annual Gross Income _____

Annual Net Income _____

- ☐ Salaried (Salary + Bonus)
- ☐ Self-employed – Sched. C (Income-Expenses)
- ☐ Partner or S-Corp (Income from K-1)

Is there other coverage in force?

Group LTD amount: _____

Benefit/Elimination Period _____

- ☐ Employer paid premium
- ☐ Employee paid premium

Individual DI amount _____

Benefit/Elimination Period _____

Quote Information

- ☐ Short Term
- ☐ Long Term

Monthly Benefit

- ☐ Max Available
- ☐ Specified Amount _____

Long Term DI

Elimination Period	Benefit Period
☐ 30-Day	☐ 2yr
☐ 60-Day	☐ 5yr
☐ 90-Day	☐ 10yr
☐ 180-Day	☐ Age 65
☐ 365-Day	☐ Age 67

Short Term DI

Elimination Period	Benefit Period
☐ 0-Day	☐ 3 Month
☐ 7-Day	☐ 6 Month
☐ 14-Day	☐ 12 Month
	☐ 24 Month

Riders

- ☐ Automatic Benefit Increase
- ☐ Catastrophic Disability
- ☐ COLA (Cost of Living Adjustment)
- ☐ Critical Illness Benefit
- ☐ Future Purchase Option
- ☐ Guaranteed Insurability
- ☐ Non-Cancelable
- ☐ Own Occupation
- ☐ Residual/Partial Disability
- ☐ Retroactive Injury Benefit
- ☐ ROP (Return of Premium)
- ☐ SDIR (Social Security DI Insurance Rider)

Art Jetter & Company – Insurance Marketing
di@jetter.com – 800-228-0008 – 402-330-5078 Fax

Disability Insurance Proposal Request

Business Overhead Expense (BOE)

Monthly Benefit

Elimination Period ☐ 30-Day ☐ 60-Day ☐ 90-Day

Benefit Period ☐ 12mo ☐ 18mo ☐ 24mo

Riders ☐ Future Purchase Option

☐ Salary of Replacement ☐ Residual

Disability Buy Out

Monthly Benefit _____

Lump Sum Benefit

Elimination Period ☐ 12mo ☐ 18mo ☐ 24mo

Benefit Period ☐ 18mo ☐ 24mo ☐ 36mo

☐ 60mo ☐ Lump Sum

Medical History

Does the client have any history of:

☐ Neck or back disorders ☐ Diabetes, High Cholesterol, or Hypertension

☐ Mental/Nervous conditions ☐ Other _____

In the last 5 years, has the client seen:

☐ Physicians ☐ Chiropractors ☐ Counselors/Psychiatrists

Is the client pregnant? ☐ Yes ☐ No

If any questions above were answered "Yes", please provide full details. List condition(s), duration, treatment, and related issues:

If the client is taking any medications, please list them below:

Medication(s)/Reason	Dosage	Frequency	Duration

Additional Notes

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