

**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 \$ _____	
<b>Employee Paid or Employer Paid</b>		

**INDIVIDUAL PLAN OPTIONS**

*Plan Choices*

<u>Standard Insurance</u>	<u>Guardian</u>	<u>Assurity</u>	<u>Ameritas</u>	<u>Principal</u>
Protector Platinum	Provider Plus	AssurityBalance	DInamic Foundation	DI Solutions
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):	Benefit Period(s):	Monthly Benefit Amount(s):
30 60 90 180 365 730	1 yr 2yr 5yr 10 yr Age 65 Age 67 Age 70	\$ _____

*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**

<b>Business Overhead Expense:</b>	<b>Buy-Sell:</b>
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/
Benefit Amount: \$ _____	Monthly - 2, 3, or 5 years
Future Purchase: Y / N	Benefit Amount: \$ _____
Residual Disability: Y / N	Extended Benefit: Y / N
# of employees (4 max) _____ (check guidelines)	Future Buy-Out: Y / N
# 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**? \_\_\_\_\_