

DIS Proposal Request Form

Quotes within 24 hours guaranteed!



Broker Information

Today's date: _____ Phone: _____ Fax: _____

Broker name: _____ Affiliation: _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail or FAX to: _____

Client Information

Client name: _____ DOB: _____

Sex: M F Tobacco user: Yes No State: _____ Net annual income: _____

Occupation: _____ Work at home: Yes No % of time: _____

Company: Business owner / Self employed C-corp # of employees: _____ Years in business: _____

Government employee? Yes No Years of government employment: _____ Federal State County City

Group LTD in force? Yes No Monthly amount: \$ _____ 60% 67% Employer paid: Yes No

Individual coverage in force: Yes No Monthly amount: \$ _____ To remain in force? Yes No

Occupation duties: _____

Medical issues or other comments: _____

Individual Disability Policy

Who will pay the premium? Employer Employee Monthly benefits: \$ _____

Elimination period: 60 90 180 365 Benefit period: 2 yrs 5 yrs to age 65 66/67

Benefit riders: SSIB _____ Residual benefits COLA Non-cancelable Return of premium CAT _____

Own Occ. Future purchase option No riders

Overhead Expense Policy

Monthly benefit: \$ _____ Elimination period: 30 60 90 Benefit period: 12 mos 18 mos 24 mos

Benefit riders: Residual benefits Future purchase option

Fax to: 217-833-2046
or

Email to: r.kennedy@emrickgroup.com