DIS Proposal Request Form –

EMRICK INSURANCE MARKETING GROUP

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