

DISABILITY PROPOSAL REQUEST

INSURED: _____ DOB: _____ SEX: _____

Tobacco Use: _____ Res. State: _____ Issue State: _____

Occupation: _____ Duties: _____ Degree: _____

Annual Income: _____ Bonus: _____ Self-Employed: _____

Inforce Coverage:

Group

Individual

Notes:

Benefit Amount: _____ Benefit Amount: _____ _____

Elim. Period: _____ Elim. Period: _____ _____

Benefit Period: _____ Benefit. Period: _____ _____

Income %: _____ _____

Cap: _____ Payor: EE ER _____

Individual:

BOE:

Buy-Out:

Monthly amount: _____ Monthly amount: _____ Monthly Amount: _____

Elim. Period: 30 60 90 180 365 Elim. Period: 30 60 90 Elim. Period: 365 540 730

Benefit Period: 2 5 65 67 70 Benefit Period: 12 18 24 Benefit Period: 24 36 60 Lump

Down Payment _____

Riders:

Res. BU ABI COLA ABI BU RES BU Ext. Benefit

SIS Non Can Own Occ

BROKER: _____

ADDRESS: _____

PHONE: _____

FAX: _____

E-MAIL: _____

FAX MAIL E-MAIL

FOR OFFICE USE ONLY:

DATE REQUESTED: _____

DATE COMPLETE: _____

DATE FAXED: _____

DATE E-MAILED: _____

COMPANY QUOTED: _____

OCCUPATION CLASS: _____