**Income Protection/Disability Insurance**

**Proposal Request**

**Date: \_\_\_ / \_\_\_ / \_\_\_\_\_\_**

Financial Professional: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_\_\_\_ Ext.: \_\_\_\_\_

Please return proposal via [ ]  Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Fax: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_\_\_\_

**Client Information:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Male [ ]  Female

Date of Birth: \_\_\_ / \_\_\_ / \_\_\_\_\_\_State of Residence: \_\_\_\_\_\_ State written in: \_\_\_\_\_\_ Tobacco use? [ ]  Yes [ ]  No

Occupation Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Premium Paid By: [ ]  Employee [ ]  Employer

Specific Daily Job Duties: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Earned Income: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Unearned Income: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is Client: [ ]  Salary Employee? [ ]  Sole Prop? [ ]  LLC/Partnership? [ ]  S-Corp Owner? [ ]  C-Corp Owner?

If business owner, length of time owned: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of employees: \_\_\_\_\_\_\_\_

Client have existing DI coverage: [ ]  Yes [ ]  No Group LTD Monthly $\_\_\_\_\_\_\_\_\_\_\_\_ Individual DI Monthly $\_\_\_\_\_\_\_\_\_\_\_

Medical Conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Carrier preference: [ ]  Ameritas [ ]  Berkshire [ ]  MassMutual [ ]  MetLife [ ]  Mutual of Omaha [ ]  Principal [ ]  Standard

**Benefits to Quote:**

Individual Disability Insurance

Monthly Benefit: $ \_\_\_\_\_\_\_\_\_ or [ ]  Maximum Available

Elimination Period: [ ]  30 days [ ]  60 days [ ]  90 days [ ]  180 days [ ]  365 days [ ]  730 days

Benefit Period: [ ]  2 years [ ]  5 years [ ]  Age 65 [ ]  Age 67 [ ]  Age 70 [ ]  Lifetime

Optional Benefits: [ ]  OwnOcc [ ]  Modified OwnOcc [ ]  Residual [ ]  COLA [ ]  FIO [ ]  CAT [ ]  SIS [ ]  Show All

Business Overhead Expense (BOE)

Monthly Benefit: $ \_\_\_\_\_\_\_\_\_\_\_\_ (Only expenses that would continue during disability)

Elimination Period: [ ]  30 days [ ]  60 days [ ]  90 days Benefit Period: [ ]  12 months [ ]  18 months [ ]  24 months

Optional Benefits: [ ]  Residual [ ]  Future Purchase [ ]  Salary of Replacement [ ]  Show All

Disability Buy-Out (DBO)

Monthly Benefit: $ \_\_\_\_\_\_\_\_\_\_\_\_ or Lump Sum Benefit: $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Total Coverage Desired: $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Elimination Period: [ ]  12 months [ ]  18 months [ ]  24 months

Benefit Period: [ ]  Lump Sum [ ]  24 months [ ]  36 months [ ]  60 months

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you need contracting for this carrier? [ ] Yes [ ] No Do you need an application sent? [ ] Yes [ ] No

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