



## Request for Disability Income Quote

Date Submitted: \_\_\_\_\_  
 Producer Name: \_\_\_\_\_  
 Producer Phone: \_\_\_\_\_  
 Producer Email Address: \_\_\_\_\_

### Client Name:

Gender:	<b>Male</b>	<b>Female</b>
Date of Birth:		
Nicotine Use/Type:	<b>Resident State:</b>	<b>Writing State:</b>
Occupation:	Occupation Class:	Annual Earned Income:
Premiums to be paid by:	Employer	Employee

### Business Owner

Years of Ownership:	Percentage of Ownership:	Number of Employees:
Corporate Structure:	C-Corp      S-Corp      Sole Prop.	Partnership

### DI Coverage Requested

<b>Monthly Benefit Amount:</b>	DI Retirement Security Amount:	Include SSI Substitute:    Amount:
<b>Elimination Period</b>	30      60      180      365	<b>Show All</b>
<b>Benefit Period</b>	2 yr   5yr   Age 65   67   70	Own Occ: 2 yr   5yr   Age 65   67   70
<b>Riders:</b>	COLA: 3%    5%                      Residual                      Recovery 1yr   3yr	
	Catastrophic Disability Benefit: Max of:                      ETDB 50   75   100	
	Benefit Update:    Automatic Increase Option/Future Benefit Increase	
	Regular Occ: (some 5A classes only)      Traditional Occ: 2/5 yr Age 65/67/70	
<b>Existing Coverage:</b>		
<b>Medical Concerns:</b>		

### Overhead Expense

Benefit Amount	\$ _____	
Elimination Period	30                      60                      90	
Benefit Period	12                      18                      24	
Riders:	Residual                      AIO                      Benefit Update	

### Disability Buy-Out

Monthly Benefit:	\$ _____	
Elimination Period	365                      540                      730	
Lump Sum:		
Benefit Period:	24                      36                      60	
Riders:	Benefit Update	