

DI Fact Finder

Requesting an Individual Disability Coverage Proposal

Advisor Information

Full Name: _____
Firm Name: _____
Address: _____
City, State, Zip: _____
Email Address: _____
Phone Number: _____

Client Information

Full Name: _____
DOB or Age: _____ Resident State: _____ Work State: _____
Gender: Male Female Smoker: Yes No Self-employed: Yes No
Occupation & Duties: _____

Years in current position: _____ If < one year, prior occupation: _____
Currently work from home: Yes No If Yes, %: _____
Annual Income: _____ Bonus: _____
Who will pay premium for desired coverage: Employer Employee
Other LTD or DI coverage: _____
Carrier: _____ Benefit Amount: _____
Known Medical History: _____

Case Design

Benefit Amount: Maximum or Other: _____
Elimination Period: 90 180 365
Benefit Period: Two years Five years Age 65
Additional Benefits: Own Occupation Catastrophic Disability Residual Disability
 Future Increase Options Cost of Living Adjustments

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