

Multi-life DI Fact Finder

Advisor Information

Full Name: _____

Firm Name: _____

Address: _____

City, State, Zip: _____

Email Address: _____

Phone Number: _____

Case Information

Business Name: _____

Main Location City: _____ Main Location State: _____

Business Entity: C-Corp S-Corp Partnership LLC LLP

Nature of Business: _____

Existing Coverage

Group Long-term Disability Coverage:

Percentage or Specified Amount: _____

Cap (if applicable): _____

Employer-paid: Yes No Other _____

Elimination Period: _____

Benefit Period: _____

Proposed Coverage

Elimination Period: 90 180 365

Benefit Period: Two years Five years Age 65 Max Available

Employer-paid: Yes No Other _____

In addition to the above, a census is required to include the following information on each individual: Name, DOB, Gender, Occupation/Job Title, Resident State/Zip Code, Salary, Bonus/Commission (if applicable).

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