DISABILITY INSURANCE

REQUEST FOR PROPOSAL

CLIENT INFO:

CLIENT NAME: _____ STATE_____

DATE OF BIRTH:_____ SEX: M___ F___ SMOKER: Y___ N ___

INDV/OWN OCCUPATION _____ BUS PROF OVERHEAD_____

OCCUPATION DESCRIPTION: _____

_____

ANNUAL INCOME $: _____ Desire monthly DI benefit $:_____

BENEFIT PERIOD: 2 YEARS ___ 5 YEARS ___ TO AGE 65 ___

WAITING PERIOD (DAYS): 30 ___ 60 ___ 90___ 180 ___ 360 ___

RIDERS:
RESIDUAL/PARTIAL _____ COST OF LIVING _____
AUTOMATIC INCREASE RIDER (AIR) _____
FUTURE INSURABILITY RIDER _____

HEALTH CONCERNS:_____
_____
_____
_____

AGENT INFO:

NAME:_____COMPANY:_____

ADDRESS:_____ Email**:_____**

TEL:_____FAX:_____

Fax To The Producers Firm
860-584-8462