DATE: _____

DISABILITY QUOTE REQUEST

Client Name: _____ State: _____

Age/D.O.B.:_____ Gender: **M** ☐ **F** ☐ Tobacco Use: **Y** ☐ **N** ☐

Job Title: _____

Salary: _____ **Business Owner** ☐ **Employee** ☐

Business Overhead: **Y** ☐ **N** ☐ Buy-out: **Y** ☐ **N** ☐

Elimination Period: _____ Benefit Period: _____

Benefit Amount: MAXIMUM ☐ _____ _____

Amount of Existing Long Term DI (Including group): _____

Carrier Requested (Pick up to 2):

Ameritas/Union Central ☐ **Guardian** ☐ **Mass Mutual** ☐ **MetLife** ☐

Mutual of Omaha ☐ **Principal** ☐ **Standard** ☐

Riders: **Own Occ** ☐ **COLA (Specify amount below)** ☐ **Residual** ☐ **Catastrophic** ☐

Future Increase Option ☐ **SS Substitute** ☐ **Other (Specify below)** ☐

Premium Mode: **A** ☐ **S** ☐ **Q** ☐ **M** ☐

Required By Date: _____ Requested By: _____

Additional Info and known Medical Conditions:

_____

_____

_____

_____

_____