Disability Insurance Questionnaire

Agent ______Ken Dicken, Business Director________________________ State/Zip KY 40241
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DISABILITY QUOTE REQUEST FORM

Client Name__________________________________ **DOB** _______ **Height** ______ **Weight** ________

Address ____________________________________ **City** __________________ **State/Zip**____________

Phone__________________ **Fax** _______________ **Cell**_________________ **Email**___________________

Sex_______**Tobacco**_____**Job Title & Duties**____

Annual Income + bonuses________________________**State**_____________________

Existing Coverage________________________**Individual**________**Group**________

Elimination Period___________________**Benefit Period**_____________________

Current Medications – list all taking along with the condition each prescribed for, length of time taken, frequency, and dosage.
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PLAN DESIGN INFORMATION

Elimination Period ________**30**______**60**________**90**_______**180**

Benefit Period_________**2yr**_________**5yr**__________**to age 65**________**to age 67**

Monthly Benefit Amount____________________

Optional Benefits_____________**Residual/Partial**________________**Cost of Living**

Catastrophic______________**Social Security blend**______________________

Automatic Benefit Increase__________________

Individual pay or Employer pay_________________________

 CONTINUE ON REVERSE SIDE(if needed)