



## Disability Insurance Questionnaire

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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.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### 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** \_\_\_\_\_