Disability Insurance: Fact Finder

Agent Information

Name _____ Tel. #_____

Email _____ Quote Needed By (MM/DD) _____

Client Information

Name _____ Gender ☐ Male ☐ Female Date of birth _____

State of Residence _____ Occupation _____

Job Duties _____ Employer _____

Annual Base Income_____ Annual Bonus _____

Annual Commissions _____ Annual RSU's_____

Length of Time with Current Employer (Years/Months) _____

College Degree? ☐ Yes ☐ No If Yes, Type _____

Business Owner? ☐ Yes ☐ No # of Years in Business_____ # of Employees_____ % of Ownership_____

Government Employee? ☐ Yes ☐ No If Yes, # of Years _____

Medical Information

Height: _____ Weight: _____

Have you had any significant weight change (10 lbs. or more) over the last 12 months? ☐ Yes ☐ No

If yes, please explain reason for weight change: _____

Blood Pressure and Cholesterol:

Latest BP reading: _____ /_____Latest total cholesterol: _____ mg; Latest cholesterol/HDL ratio: _____

Have you ever had, been told you had, or been treated for any of the conditions listed? (check all that apply)

- ☐ ADD/ADHD
- ☐ Asthma
- ☐ Cancer
- ☐ Chronic Fatigue
- ☐ Cirrhosis
- ☐ COPD
- ☐ Coronary artery disease
- ☐ Cerebrovascular disease
- ☐ Colitis or Crohn's disease
- ☐ Dementia/cognitive impairment
- ☐ Depression/anxiety
- ☐ Diabetes
- ☐ Drug abuse
- ☐ Fibromyalgia
- ☐ Heart murmur/valve disease
- ☐ Hepatitis
- ☐ Internal organ transplant
- ☐ Irregular heartbeat/palpitations
- ☐ Kidney disease
- ☐ Lupus
- ☐ Multiple sclerosis
- ☐ Peripheral vascular disease
- ☐ Rheumatoid arthritis
- ☐ Seizure
- ☐ Sleep apnea
- ☐ Stroke or TIA
- ☐ Vertigo
- ☐ Other_____

Have any treatments or procedures been recommended but not yet completed? ☐ Yes ☐ No

Tobacco/Nicotine Use

Have you ever used any kind of tobacco product? ☐ Yes ☐ No

Date of last usage: _____

Drug/Alcohol Use

Do you currently drink alcohol? ☐ Yes ☐ No Date of last consumption: _____

Type of Alcohol: _____ Frequency: _____

Type of Alcohol: _____ Frequency: _____

Have you ever consulted a doctor or received treatment for alcohol abuse? ☐ Yes ☐ No

Have you ever been arrested for driving under the influence of alcohol? ☐ Yes ☐ No (If Yes, date: _____)

Have you ever used illegal drugs, consulted a doctor, or received treatment for drug abuse? ☐ Yes ☐ No

Types of Drugs Used: _____

Date(s) Last Used: _____ Are you currently involved in a 12-Step Program? ☐ Yes ☐ No

Marijuana Use

Have you ever used any kind of marijuana/CBD product? ☐ Yes ☐ No

If yes, reason for use: ☐ Recreational ☐ Medicinal

Delivery method: ☐ Ingested ☐ Vaporized ☐ Smoked ☐ Other _____

Frequency: _____ Date of last usage: _____

If medicinal, reason prescribed _____ Frequency: _____

Hazardous Activities - Only complete if applicable

Do you participate in any of the following activities? (check all that apply)

- ☐ Base Jumping
- ☐ Caving
- ☐ Flying as a Pilot
- ☐ Hang Gliding
- ☐ Heli-skiing
- ☐ Parachute Jumping
- ☐ Racing
- ☐ Rock Climbing or Mountaineering
- ☐ Rodeo
- ☐ Skydiving
- ☐ Underwater Diving

Please provide details.

_____

_____

_____

_____

Disability Insurance: Fact Finder

Doctor Information

Primary care physician's name: _____

Address: _____

Tel. #: _____

Date last seen: _____ Reason for visit: _____

Please list all doctors seen in the last 5 years along with reason for visit:

Name/specialty: _____ City, State: _____

Tel. #: _____ Date seen/reason: _____

Name/specialty: _____ City, State: _____

Tel. #: _____ Date seen/reason: _____

Inforce Coverage Details

Group LTD Inforce? ☐ Yes ☐ No

% of Income Covered? _____ Monthly Benefit Cap? _____

Income Covered (Check All That Apply) ☐ Base Salary ☐ Bonus ☐ Commission ☐ RSU's

Elimination Period _____ Benefit Period _____

Replacing Policy? ☐ Yes ☐ No

Other Individual DI Inforce? ☐ Yes ☐ No

Monthly Benefit Amount _____

Elimination Period _____ Benefit Period _____

Replacing Policy? ☐ Yes ☐ No

Individual Income Protection Design Request

Maximum or Specific Benefit Amount _____

Elimination Period ☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ 180 Days ☐ 365 Days

Monthly Benefit Amount _____

Benefit Period ☐ 6 Months ☐ 1 Year ☐ 2 Years ☐ 5 Years ☐ 10 Years
☐ To Age 65 ☐ To Age 67 ☐ To Age 70

Benefit Riders ☐ Residual ☐ Own OCC ☐ Non-Can ☐ Future Purchase ☐ COLA ☐ Catastrophic
☐ Social Offset ☐ Return Of Premum ☐ Student Loan Repayment

Business Overhead Expense Plan Design Request

Monthly Benefit Amount _____

Elimination Period ☐ 30 Days ☐ 60 Days ☐ 90 Days

Benefit Period ☐ 12 Months ☐ 18 Months ☐ 24 Months

Benefit Riders ☐ Residual ☐ Future Purchase ☐ Professional Replacement ☐ Loan Protection

Length of Loan _____Loan Payment _____

Additional Details

Are there any additional details that could impact this case?

_____

_____