Individual Disability Income Proposal Request Form

Broker: _____Address _____

Phone_____Fax_____Email: _____

Individual Disability	**Disability Buy-Sell**

Individual Disability

Client's Name: _____ Gender: _____

DOB/Age: _____ Tobacco: _____ State: _____

Annual Income: _____ Occ Class: _____

Occupation: _____

Exact
Duties/Specialty:_____

Health
Conditions/Meds:_____

In-Force Disability? (Ind,Group,Assoc): _____

Multi-Life Discount / 2-4 lives (10%)   5+ lives (15%)
Association Discount? (AMA, BAR, Etc)   15%

Plan Design: Non-Cancellable (NC)   Guarantee Renewable (GR)

Premium: Level   Step-Rate   or   Both

Mode: Monthly EFT   Qtrly   Semi-annual   Annual

EP: 60   90   180   365

BP: 2-Yr   5-Yr   10-Yr   To65   To67   To70

Benefit Amount: Maximum   or $_____

Employee Pay   or   Employer Pay

Optional Riders (may not be available for all carriers/designs)
Residual   Social Security Offset (SSIR)   Own Occ

FIO (age 18-50)   AIR (age 18-55)   Return of Premium

COLA Simple   or   Compound   Catastrophic Benefit

Disability Buy-Sell

1. Client's Names: T/NT Age: Income: %Owned

	T/NT	Age	Income	%Owned
_____	___	____	$_____	_____
_____	___	____	$_____	_____
_____	___	____	$_____	_____
_____	___	____	$_____	_____
_____	___	____	$_____	_____

2. Company Name: _____
3. Estimated Value of Company: $_____
4. Years in Business (2 yr min): _____

5. Type of Buyout: Entity   Cross   Trustee

6. Amounts Requested:
    A. Maximum Lump Sum Benefit: Elimination Period
        $_____   365   547   730

    B. Maximum Monthly Install: Elimination Period
        $_____/month   365   547   730

    C. Initial Down Payment: $_____ Elimination Period
        Maximum Lump Sum Amount: 365   547   730

        Maximum Monthly Install Amount:
        $_____/month

Install Period: 12   24   36   48   60   months

7. Guaranteed Insurability Benefit:
    A. No   B. Yes

      Option Amount(s):
      Maximum Lump Sum $_____
      Maximum Monthly Install $_____ month

Business Overhead Expense

Elimination Period: 30   60   90   Benefit Amount: $_____

Benefit Period: 12 Months   18 months   24 Months   **Optional Riders:** FIO   Substitute Salary (SSE)

Total # Employees:_____   Years Owned_____   Other inforce BOE Coverage:$_____

Other Comments/products: Key-Man DI, Retirement DI, Business loan indemnification, critical illness, LTD, STD, GSI, etc.
_____
_____

PLEASE SEND YOUR REQUEST TO:
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