iia Brokerage Disability Insurance Proposal Request Form

YOUR INFORMATION:

*Name:*____*Date:*___________________

*Phone:*___________________ *Fax:*__________________ *E-mail:*______________________

Address: ____

____

Producers Social Security # ____

CASE INFORMATION: Circle one:

*Client Name:*____ *MALE* *FEMALE*

*Date of Birth:*____________ *Tobacco Use:* Y / N *State Lives:*_________ *Works:*__________

*Occupation:*_____________________________________ *Title:*______________________

*Duties:*____

____

*Annual Salary: $*__________________ *Bonus: $*______________ *Unearned: $*___________

If in Sales, 3 Year Average required.

GOVERNMENT EMPLOYEE? Y /N

INDEPENDENT CONTRACTOR, SELF-EMPLOYED, OR BUSINESS OWNER? Y / N

*NET INCOME: (3 year average) $*________________ *WORKS FROM HOME? Y / N*

 # Of Years As Owner? ____________ *If less than 1 full Year -*

Former Position /Duties: ________________________________ *Former Salary: $*___________

Circle one: *C- Corp* *S-Corp* *Partnership* *LLC* *# of Full Time Employees:* _________________

INDIVIDUAL CASE DESIGN:

*Benefit Amount: $*____________*or MAX* *Premium Payer: Employer*______% *Employee*_____%

Elimination Period(s): ____________________ *Benefit Period(s):* __________________________

*Options: Partial/Residual*_____ *Cost of Living* ____ *Future Purchase Rider:$*_____________

*Automatic Increase:*____________________*Retirement Plan Deferral:$*_____________________

*Other Requests:*____

____

____

____

Case Name: ____

BUSINESS OVERHEAD EXPENSE CASE DESIGN:

Monthly Expenses:$________________ Elimination Period:______________________

Benefit Period: 12 Months____ 18 Months_____ 24 Months_____Show Alternatives_____

Options:
Partial/Residual: ______Future Purchase Option:______ Professional Replacement: ______

Inforce BOE Coverage Amount:__________________ Replacing? Y /N

COVERAGE IN-FORCE: (check all that apply)

Individual:__________Group LTD: __________ Combination:______________ NONE________

GROUP LTD: Carrier: __________________ Replacement %_______ Benefit Maximum $__________

Premium Payer: Employer________% Employee ________%

Income Covered: Salary _____ Overtime_____ Bonus____ Commissions____ Retirement Contrib.____

Benefit Amount: $____________ Waiting Period:_______________ Benefit Period: _______________

INDIVIDUAL DI: Carrier:____________________________________ Benefit Amount $__________

Waiting Period:____________Benefit Period:__________Taxable Benefits? Y / N Replacing? Y/N

Is there competition on the case?____

____

____

Health Problems (Past 5 yrs.), Taking Medications, Height / Weight? ___________________________

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Fax back to: Charles Carr

1-847-619-1793

If you have any further questions please contact us at 1-847-619-1790.