BROKERHOUSE
INSURANCE

Disability Income Proposal Request

Agent Name: _____ Email: _____
Phone: _____ Fax: _____

Proposed Insured:

Name: _____ Date of Birth: ____/____/_____ Resident State: _____
Gender: ☐ Male ☐ Female / Tobacco Use: ☐ Yes (Type: _____) ☐ No / Height: _____Weight: _____
Occupation: _____

Provide Specific Duties: (If physician – please indicate specialty. If applicable – year of residency. Business Owner - (Brief description of duties, # of employees, # of years in business, type of business). Do you work from home: ☐Yes ☐ No If yes, percentage of time: _____%

_____

_____

Medical Conditions / Medications: _____

_____

☐ **DISABILITY INCOME**

Benefit Amount:

Annual Earned Income $ _____ Last Year's Income: $_____

Specific Amount $ _____ or ☐ Maximum Available

Existing Coverage: ☐ None ☐ Yes (answer questions below)

DI Coverage $ _____ Paid By: ☐ Employer ☐ Employee

Group LTD Coverage $ _____ Paid By: ☐ Employer ☐ Employee

Percentage: _____% Cap/Max: _____

Is this replacement coverage: ☐ Yes ☐ No

Waiting Period: ☐ 30 ☐ 60 ☐ 90 ☐ 180 ☐ 360 ☐ 720

Benefit Period ☐ To age 65/67 ☐ 60 months ☐ 24 months ☐ Lifetime

Mode of Payment: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

Premiums to be Paid by: ☐ Employee ☐ Employer (C-Corp, S-Corp, Partnership or Sole Proprietorship)

Riders: ☐ Residual ☐ COLA ☐ Future Purchase Option ☐ Own Occ
☐ Other _____

☐ **OVERHEAD EXPENSE:**

Existing Coverage: ☐ None ☐ Yes: Amount: _____ Waiting Period: ☐ 30 ☐ 60 ☐ 90

Benefit Period: ☐ 12 months ☐ 18 months ☐ 24 months / Monthly Expenses: _____