DISABILITY INCOME INSURANCE PROPOSAL REQUEST

DATE:_____ ADVISOR NAME: _____

PHONE:_____ FAX:_____ EMAIL:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

RETURN PROPOSAL BY: ☐ EMAIL ☐ FAX ☐ MAIL ☐ AGENT PICK UP NEEDED BY:____/____/____

INCLUDE SALES MATERIAL (IF AVAILABLE) ☐ YES ☐ NO RESET FORM

CLIENT INFORMATION:

CLIENT NAME:_____ DATE OF BIRTH:_____

TOBACCOSTATUS:_____

HEALTH CONDITIONS/MEDICATIONS:_____

_____

SELF EMPLOYED: ☐ YES ☐ NO IF YES, HOW LONG?_____YEARS STATE OF SALE:_____

ANNUAL INCOME:_____ OCCUPATION AND DUTIES:_____

_____

POLICY INFORMATION: Complete the appropriate section(s)

	LONG-TERM DISABILITY INCOME (LTDI)	SHORT-TERM DISABILITY INCOME (STDI)
BENEFIT AMOUNT:	☐ MONTHLY $_____ or ☐ MAX	☐ MONTHLY $_____ or ☐ MAX
BENEFIT PERIOD:	☐ 2YR. ☐ 5YR. TO AGE: ☐ 65 ☐ 67 ☐ 70	☐ 3 MO. ☐ 6 MO. ☐ 12 MO. ☐ 24 MO.
ELIMINATION PERIOD:	☐ 60 ☐ 90 ☐ 180 ☐ 365 (DAYS)	☐ 0/7 ☐ 7 ☐ 0/14 ☐ 14 ☐ 30 ☐ 60 ☐ 90 (DAYS)
RIDERS/OPTIONS:	☐ SOCIAL INSURANCE SUPPLEMENT ☐ AUTOMATIC INCREASE ☐ FUTURE INCREASE ☐ RESIDUAL ☐ COLA ☐ CATASTROPHIC ☐ RETURN OF PREMIUM ☐ 50% ☐ 80% ☐ TRUE OWN OCCUPATION	☐ HOSPITAL CONFINEMENT ☐ CRITICAL ILLNESS ☐ RETURN OF PREMIUM o 50% o 80%

	OVERHEAD EXPENSE	BUY-SELL	KEY PERSON
BENEFIT AMOUNT:	MONTHLY $_____	LUMP SUM $_____ MONTHLY $_____ ☐ COMBINE BOTH	LUMP SUM $_____ OR LUMP/MONTHLY $_____
BENEFIT PERIOD:	☐ 12 MO ☐ 18 MO ☐ 24 MO	☐ 24 MO ☐ 36 MO ☐ 60 MO	
ELIMINATION PERIOD:	☐ 30 ☐ 60 ☐ 90 (DAYS)	☐ 365 ☐ 540 ☐ 730 (DAYS)	☐ 90 ☐ 180 ☐ 365 ☐ 730 (DAYS)
RIDERS/OPTIONS:	☐ RESIDUAL ☐ FUTURE INCREASE ☐ BUSINESS LOAN	☐ FUTURE INCREASE	

ADDITIONAL INFORMATION: _____

SUBMIT OR SEND TO **plusmarketing@pfnins.com**

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