



Disability Income Quote Request

Applicant's name _____ Resident state _____ Date of birth ____ / ____ / ____

Do you have disability income now (including coverage through an employer) with another provider? Yes No Benefit amt. _____ Elimination _____ Benefit period _____

Have you ever filed for bankruptcy? _____ Date ____ / ____ / ____

Job duties (be specific) _____

W2 employee or self-employed? _____ If W2 employee, list monthly income \$ _____

If self-employed: For how long? _____ What percentage of the company do you own? _____

How many employees are employed by the business? _____

Do you work out of your home? Yes No If YES, what percentage of time do you work from home? _____

Taxable earned income for this year \$ _____ Last year \$ _____

Height ____ ft. ____ in. Weight _____ Male Female

Has the Proposed Insured had a change in weight of more than 10 pounds this past year? Yes No

Has the Proposed Insured ever used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? Yes No

If YES, please list type _____ amount per day _____ last date of use ____ / ____ / ____

Are you currently taking any prescribed medications, or in the past three years have you been prescribed any medications? Yes No

Medication	Daily Dosage	Date Originally Prescribed

Back and/or neck problems? Yes No Chiropractic treatment? Yes No Last date seen ____ / ____ / ____

Have you ever participated in a sleep study, been diagnosed with sleep apnea or other respiratory disorder, or ever used a c-pap machine? Yes No

Diabetes? Yes No Type I Type II Age at onset _____

Hypertension? Yes No Date of diagnosis ____ / ____ / ____ Last reading _____, date ____ / ____ / ____

Skin cancer or tumors? Yes No Type and location _____ Last treatment date ____ / ____ / ____

Drug and/or alcohol abuse? Yes No Type of drug _____ Amount of alcohol _____

Treatment dates _____ Involvement in support groups Yes No Which? _____

Have you had a natural parent or sibling who was diagnosed with or died of cancer, heart disease or diabetes prior to the age of 60? Yes No

If YES, list relationship, diagnosis and age of diagnosis. _____

Other medical history:

Empty box for other medical history.

Elimination period requested _____ Benefit period requested _____

Agent's name _____ Phone no. _____ Email _____