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:

Elimination period requested _____ Benefit period requested _____

Agent's name _____ Phone no. _____ Email _____

Secure Email form to crhyne@producersxl.com or Fax to 785-825-1391