Disability insurance proposal request

Agent information

Agent name: _____ Telephone: _____ Ext.: _____

Contact: _____ Affiliation: _____

How should we return the illustration? (Please check one)

☐ Email: _____ ☐ Fax: _____ ☐ Other: _____

Client information

Client name: _____ ☐ Male ☐ Female

Date of birth: _____ State of residence: _____ State written in: _____

Is he/she a United States citizen? ☐ Yes ☐ No Tobacco use? ☐ Yes ☐ No

Occupation (Be specific): _____ Work 30 or more hours per week? ☐ Yes ☐ No

Salary or net income: $_____

Specific duties (Time spent doing each): _____

Is client: ☐ Salary employee? ☐ Sole prop? ☐ LLC/Partnership? ☐ S corp owner? ☐ C corp owner?

If business owner, length of time owned? _____ Number of employees: _____

Is there other coverage in force? ☐ Yes ☐ No Group LTD $ _____ Individual DI $ _____

Medical conditions: _____

_____

Carrier preference: _____

Benefits to quote: Disability Insurance

Monthly benefit: $_____ or ☐ Maximum available

Elimination period: ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days ☐ 365 days ☐ 730 days

Benefit period: ☐ 2 years ☐ 5 years ☐ Age 65 ☐ Age 67 ☐ To Age 70

Optional benefits: ☐ Own occ ☐ Residual ☐ COLA ☐ Future purchase ☐ Social Security rider ☐ Show all

Benefits to quote: Business Overhead Expense (BOE)

Monthly benefit: $_____ (Only expenses that would continue during disability)

Elimination period: ☐ 30 days ☐ 60 days ☐ 90 days

Benefit period: ☐ 12 months ☐ 18 months ☐ 24 months

Optional benefits: ☐ Residual ☐ Future purchase ☐ Salary of replacement ☐ Show all

Benefits to quote: Disability Buy-Out (DBO)

Monthly benefit: $_____ or Lump sum benefit: $_____ Total coverage desired: $_____

Elimination period: ☐ 12 months ☐ 18 months ☐ 24 months

Benefit period: ☐ Lump sum ☐ 24 months ☐ 36 months ☐ 60 months

Comments: _____

Contact the LWT Disability Solution Center at 800.998.3382, option 2, option 2 or email DIsales@lwtsolutioncenter.com for more information.

LWT
Leisure Werden & Terry