INDIVIDUAL DISABILITY QUOTE REQUEST

Kouzmanoff Financial & Insurance Services, Inc.
"The DI Guys"

Fax to: (310) 792-7360 or Email to: tbishop@thediguys.com

BROKER NAME: Steve Shorr **CA LIC#:** 0596610 **DATE:** _____

COMPANY/AGENCY NAME: Steve Shorr Insurance

ADDRESS: 1027 W. 11th Street # 3

CITY: San Pedro **STATE:** CA **ZIP:** 90731

EMAIL: Steve@SteveShorr.com **PHONE:** 310.519.1335

ILLUSTRATION WILL BE: ☑ EMAILED TO ABOVE ADDRESS ☐ FAXED TO_____ ☐ MAILED

CLIENT NAME: _____

SEX: ☐ M ☐ F **DATE OF BIRTH:** _____ / _____ / _____ **STATE OF RESIDENCE:** _____

TOBACCO OR NICOTINE USE (INCLUDING GUM, PATCH OR OTHER NICOTINE) IN THE PAST 12 MONTHS? ☐ NO ☐ YES

OCCUPATION: _____

DESCRIBE **DAILY OCCUPATIONAL DUTIES:** _____

_____

EMPLOYEE OF A GOVERNMENT ENTITY? ☐ NO ☐ YES **IF YES, WHICH ENTITY?** (SELECT ONE)

HOW MANY YEARS OF SERVICE? _____

WHAT *PERCENTAGE* OF OCCUPATIONAL DUTIES IS PERFORMED FROM RESIDENCE / HOME? _____%

WORK IN OCCUPATION 30 OR MORE HOURS *PER WEEK*? ☐ NO ☐ YES

INCOME (*AFTER BUSINESS EXPENSES*) **(1) LAST TAX FILING $** _____ **(2) YEAR TO DATE $**_____

(1) SELF EMPLOYED *OR* HAS > 25% BUSINESS OWNERSHIP? ☐ NO ☐ YES **IF YES, HOW MANY YEARS** _____ **/ # OF EES** _____

(1a) BUSINESS OPERATES AS: (SELECT ONE)

ANY *INDIVIDUAL* DISABILITY COVERAGE IN FORCE? ☐ NO ☐ IF YES, $ _____ **MONTHLY BENEFIT**

ANY *GROUP* DISABILITY IN FORCE? ☐ NO ☐ IF YES, _____% TO $ _____ **MAX. MO. BENEFIT**

ANY BUSINESS OVERHEAD COVERAGE IN FORCE? ☐ NO ☐ IF YES, $ _____ **MONTHLY BENEFIT**

PREMIUMS TO BE PAID BY? **INDIVIDUAL** **EMPLOYER**

PLAN & BENEFITS TO BE QUOTED?	**INDIVIDUAL DISABILITY**	**BUSINESS OVERHEAD**	**BUY-OUT**
WAITING PERIOD (DAYS):	☐ 60 ☐ 90 ☐ 180 ☐ 365 ☐ 730	☐ 30 ☐ 60 ☐ 90	☐ 365 ☐ 570 ☐ 730
BENEFIT PERIOD:	☐ 2 YRS ☐ 5 YRS ☐ TO AGE 65-67-70	☐ 12 ☐ 18 ☐ 24	☐ MO. ☐ LUMP SUM
***REQUESTED MONTHLY BENEFIT AMT.**	$_____	$_____	$ _____

****MAXIMUM BENEFIT* *AMOUNTS WILL BE QUOTED IF A REQUESTED AMOUNT IS NOT INDICATED***

OPTIONAL RIDERS TO BE QUOTED? ☐ **ALL RIDERS** ☐ **FUTURE PURCHASE** ☐ **COLA** ☐ **ADL (CAT)**

TAKING PRESCRIBED MEDICATIONS? ☐ **NO** ☐ **YES**

IF **YES, FOR *WHAT CONDITION(S)* AND *MED NAME*?**

SPECIAL HEALTH OR OTHER UNDERWRITING CONSIDERATIONS:

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(2/2015)