# Disability Income Proposal Request

Agent Name: Steve Shorr Insurance  Email: Steve@SteveShorr.com

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**INSURED:** Name: _____ **Date of Birth**: (not age)_____

State: _____ **Gender**: ☐ Male ☐ Female

Occupation: _____

Specific Duties (**If physician – please indicate specialty**. If applicable – year of residency)
Business Owner (brief description of duties, # of employee, # of yrs in business, type of business)
Do you work from home: ☐Yes ☐ No If yes, percentage of time: _____%

**Tobacco Use**: ☐Yes (Type: _____) ☐ No **Height**: _____ **Weight**: _____

Additional Medical History: _____

☐ **DISABILITY INCOME**

**Benefit Amount**:

Annual Earned Income $ _____ Last Year's Income: $_____

Specific Amount $ _____ or ☐ Maximum Available

Existing Coverage: ☐ None ☐ Yes (answer questions below)

DI Coverage $ _____ Paid By: ☐ Employer ☐ Employee

LTD Coverage $ _____ Paid By: ☐ Employer ☐ Employee

Percentage: _____% Cap/Max: _____

Is this a replacement coverage: ☐ Yes ☐ No

Has client ever been declined disability coverage: ☐ Yes (year, carrier, reason _____) ☐ No

**Waiting Period**: ☐ 30 ☐ 60 ☐ 90 ☐ 180 ☐ 360 ☐ 720

**Benefit Period** ☐ To age 65/67 ☐ 60 months ☐ 24 months ☐ Lifetime

**Mode of Payment**: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

**Premiums to be Paid by**: ☐ Employer (C-Corp, S-Corp, Partnership or Sole Proprietorship)
☐ Employee

**Riders**: ☐ Residual ☐ COLA ☐ Future Purchase Option ☐ Other: _____
☐ Own Occ ☐ Non-cancelable

☐ **DISABILITY BUY-OUT:**

Waiting Period: ☐ 12 month ☐ 18month ☐ 24month

Benefit Period: ☐ Lump Sum ☐ Monthly ☐ 2 year ☐ 3 year ☐ 5 year

Business Value: $_____ Percent of Ownership: _____

☐ **OVERHEAD EXPENSE:**

Existing Coverage: ☐ None ☐ Yes: Amount: _____

Waiting Period: ☐ 30 ☐ 60 ☐ 90

Benefit Period: ☐ 12 months ☐ 18 months ☐ 24 months

Monthly Expenses: _____

Comments: _____