DISABILITY INSURANCE PROPOSAL REQUEST FORM

Attn: Cary Stancil (Cary@LifeMarketers.com) Ph: 804-897-5446

Today's Date: _____ Response Needed By: _____
Agent: _____ Phone: _____
Email: _____

Client's Name: _____ State of Residence: _____
Current Age: _____ DOB: _____ Height: _____ ft _____ in Weight: _____
Does client use any form of tobacco? ☐Y ☐N Type: _____

Salary: $ _____ Bonus and/or Commissions: $_____
Client's Occupation & Job Description: _____

Medical Occupation: ☐Medical Student ☐Resident ☐Fellow ☐New in Practice ☐Working
Medical Specialty: _____ Resident Medical School: _____

Dental Occupation: ☐Dental Student ☐Resident ☐Fellow ☐New in Practice ☐Working
Dental Specialty: _____

Is your client a business owner? ☐Y ☐N If yes, number of years business owned: _____
Income after Business Expenses: $_____ # of employees: _____ % of time outside office: _____%
Type of Business: ☐Sole Proprietor ☐Partnership ☐"C"- Corp ☐"S"- Corp/LLC
Who will pay premiums? ☐Individual ☐Employer

Monthly Benefit: ☐Maximum ☐Other: $_____
Integrate with Social Security? ☐Y ☐N
Elimination Period (days): ☐30 ☐60 ☐90 ☐180 ☐365
Benefit Period: ☐2 yrs ☐5 yrs ☐10 yrs ☐to age 65 ☐to age 67 ☐to age 70
Own Occ Period: ☐2 yrs ☐5 yrs ☐10 yrs ☐to age 65 ☐to age 67 ☐to age 70

Optional Benefits:

☐Residual	☐Extended Disability Benefit	☐Benefit Update
☐Cost of Living	☐Our Occupation	☐Student Loan Rider
☐Future Benefit Increase	☐Transitional Your OCC	☐Retirement Protection Rider

DI Remaining In-force: _____ ☐Individual ☐Group
Group LTD/Employer Paid/Individually Paid Benefit Cap: _____ % of Salary: _____%

Any Health Conditions?
☐Diabetes ☐Back Treatment ☐Heart/Circulatory ☐High Blood Pressure ☐Mental/Nervous Disorder
☐Cancer ☐Drug/Alcohol (Type, amount, frequency): _____
☐Other: _____
Date each condition diagnosed: _____
List all medications along with dosage, frequency, and duration: _____