E-MAIL COMPLETED FORM TO QUOTES@DISERVICES.COM
FAX COMPLETED FORM TO 619-325-8444

DIS Proposal Request Form—
Quotes within 24 hours guaranteed!

Broker Information

Today's Date: Phone: Fax:

Broker's Name (as name should appear on proposal): Affiliation:

Address:

City: State: ZIP:

Email or FAX to: Email copy to:

Client Information

Client Name: DOB:

Sex: ❍M ❍F Tobacco User: ❍Yes ❍No State:

Gross Annual Income (W-2): $ - OR - Net Annual Income (Self-Employed): $ Pension Income: $

Occupation: Work at Home: ❍Yes ❍No % of time:

Occupational Duties:

Company: ❍Business Owner / Self-Employed ❍C-corp Number of Employees: Years in Business:

Government Employee: ❍Yes ❍No Years of Government Employment: ❍Federal ❍State ❍County ❍City

Group LTD in Force: ❍Yes ❍No Monthly Amount: $ ❍60% ❍67% Employer Paid: ❍Yes ❍No

Individual Coverage in Force: ❍Yes ❍No Monthly Amount: $ To Remain in Force: ❍Yes ❍No Carrier:

Medical Issues or Other Comments:

Individual Disability Policy

Who Will Pay the Premium? ❍Employer ❍Employee Monthly Benefits: $ Client's Monthly Budget: $

Elimination Period: ❍30 ❍60 ❍90 ❍180 ❍365 Benefit Period: ❍2 Yrs. ❍5 Yrs. ❍To age 65 ❍66/67

Benefit Riders: ❍SSIB __________ ❍Residual Benefits ❍COLA ❍Non-cancelable ❍Return of Premium ❍CAT __________
❍Own-Occ. ❍Future Purchase Option ❍Automatic Increase Benefit (AIB) ❍No Riders ❍DIS Recommendation

Critical Illness: Amount: $

Would you like a long-term care insurance quote as well? ❍Yes ❍No

Overhead Expense Policy

Monthly Benefit: $ Elimination Period: ❍30 ❍60 ❍90 Benefit Period: ❍12 mos. ❍18 mos. ❍24 mos.

Benefit Riders: ❍Residual Benefits ❍Future Purchase Option

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