

Disability Proposal Request

Proposal to be Faxed Mailed E-Mailed

Agent Name: _____

Address: _____ City, State & Zip: _____

Date: _____ Telephone: _____ Fax: _____ E-Mail _____

Client's Name: _____ Age/DOB: _____

Sex Male Female State of Residence: _____ Occupation/Class: _____

How Paid Employee Employer Rating _____ % Tobacco User Yes No

Current in Force Group LTD Individual Annual Income \$ _____

PLEASE INDICATE DI or DOE

Benefit Amount \$ _____

Plan

Waiting Period _____

To Age 65 _____

5 Years _____

2 Years _____

1 Year _____

Discounts:

- Associations
- Multi-Life
- Double Annual

Please indicate the following riders:

- Residual
- Inflation
- Social Insurance Amount \$ _____
- GPIR Amount \$ _____
- ADL Amount \$ _____
- Salary Substitute (DOE ONLY) Amount \$ _____
- Future Increase (DOE ONLY) Amount \$ _____

Additional Notes: _____
