

Disability Income Proposal Request Form

Broker: _____ Phone: _____

Email: _____ Fax: _____

Address: _____

Individual Disability

Client: _____ Gender: _____

DOB/Age: _____ Tobacco: _____ State: _____

Annual Income: \$ _____ Occ Class: _____

Occupation: _____

Exact Duties: _____

Health Conditions: _____

Medication(s): _____

In-Force DI? (Ind, Group, Assn): _____

Plan Design

Non-Cancellable Guarantee Renewable

EP: 60 90 180 365 730

BP: 2-Yr 5-Yr To65 To70

Benefit Amount: Maximum or \$ _____

Employee Paid Employer Paid

Inflation: COLA Simple Compound

Optional Riders: *(may not be available for all occ. classes)*

Residual Transitional Your Occupation S.I.O

Own Occupation Guar. Insurability LTC GPO

Lifetime Ben. Ret. of Premium Catastrophic

Disability Buy-Sell

Client Names	Tobacco	Age	Income
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Company Name: _____

Estimated Value of Company: \$ _____

Years in Business (2 year minimum): _____

Type of Purchase: Entity Cross Trustee

Amounts Requested:

Maximum Lump Sum Benefit: Elimination Period
 \$ _____ 365 547 730

Maximum Monthly Install: Elimination Period
 \$ _____ 365 547 730

Initial Down Payment: Elimination Period
 \$ _____ 365 547 730

Maximum Lump Sum Amount:
 \$ _____

Maximum Mo. Install Amount: Install Period (mo.)
 \$ _____/mo. 12 24 36 48 60

Guaranteed Insurability Benefit: No Yes

If yes, then provide Option Amount(s) below:

Maximum Lump Sum: \$ _____

Maximum Monthly Install: \$ _____/month

Business Overhead Expense

Elimination Period: 30 60 90

Benefit Period: 12-Mo. 24-Mo.

Benefit Amount: \$ _____

Total # of Employees: _____

Years Owned: _____

Optional Riders:

Guaranteed Insurability Return of Premium

Other In-Force BOE Coverage: \$ _____

Please send your completed request to Jenny Ausman

jenny@simondavisinc.com ♦ fax: 303.860.8956 ♦ phone: 303.633.5912

SimonDavis Brokerage Services, Inc. ♦ 730 17th Street, Suite 107, Denver, CO 80202