

DISABILITY WORKSHEET

Date: _____

Client Name: _____ Date of Birth: _____

Occupation: _____ *Annual Income: _____

Duties: _____

Monthly Benefit Amt: _____ Residual: Yes No

Elimination Period: _____ FIO: Yes No

Benefit Period: _____ COLA: Yes No

FIELD UNDERWRITING QUESTIONS

Do you work out of your home? No Yes

Do you own your own business? No Yes

- If yes, how many employees do you have? _____

Do you travel for business? No Yes

- If yes, what percentage of time is spent traveling and to where? _____

In the past 5 years, has your driver's license been suspended or revoked, or have you been convicted of any moving violations or accidents? No Yes (if yes, please explain)

Are you currently, or have you ever used tobacco or nicotine products? No Yes
 If yes, last date used & what form or products (cigarettes, cigars, pipe, chewing tobacco or nicorette gum)

Current height & weight: _____ Current Blood Pressure & Cholesterol: _____

Have you been hospitalized in the last 5 years? No Yes (if yes, please explain)

What current prescriptions are you taking? Please indicate the name, dosage & times taken daily:

Do you have any medical conditions not listed above? No Yes (if yes, please explain)

****Annual Income – Insurers require Tax documentation with submission***

THIS DOCUMENT FOR QUOTING PURPOSES ONLY. OFFER OF COVERAGE WILL BE SUBJECT TO FULL UNDERWRITING.