Senior Health Plan
SPECIALISTS • INC
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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)*

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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)*

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

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

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

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

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Annual Income – Insurers require Tax documentation with submission

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