Disability Insurance - Quote Request Form

Please fax or e-mail to: 801-226-0986 or info@insurawest.com

General Information	
Client Name:	Gender:
Date of Birth:	State of Residence:
Address:	

Employment	
Occupation:	Years in Profession:
Job Duties(and % of time for each)	
(Notes- Onsite duties, Travel, Hazardous,etc.):	
Income (W-2) (or Owner Gross minus Expenses):	Bonus:
Self Employed (Y/N):	# or Employees:
% of Ownership:	% Work at Home:
Years Owning Business:	Business Type (Sole Prop, C-Corp, S-Corp, LLC):

Medical	
Tobacco Use ? (if quit: When?):	Height/Weight:
Anti-depressants (Y/N):	Chiropractor (Y/N):
Medical Issues/ Medications:	

Proposed Income Protection			
Employ(er), (ee) Paid:		Waiting Period: (30,60,90,180,other):	
Benefit Period (1,2,5,10, to 65)		Benefit Amount: (maximum?)	
Existing Individual DI coverage:		Existing Group/ Work Long Term DI:	
Available Riders: (check all riders desired for quote)			
Residual (partial benefit for partial pay loss):		COLA (annual benefit increase of 3% or 6%) :	
Non- Cancellable (permanent fixed premiums):		Own-Occ (may work another job while disabled):	
Future Purchase (allows benefits increase upon raise):		Social Offset (less premium/benefit by using SSI):	
Return of Premium (repays premiums minus claims):		Catastrophic (more benefit for 2 of 6 ADL'S):	