Insured:

Name:_____ Date of Birth: _____

State:_____ Gender: Male or Female Height:_____ Weight: _____

Phone Numbers:_____ Home Phone: _____

Best time/Phone # to call back & follow up if Questions: _____

Occupation: _____ _____

Work from Home: Y or N If yes, % of time:_____%

Tobacco Use: Y or N If yes, type:_____

Additional Medical History: _____ _____ _____

Individual Disability Income:

Benefit Amount:

Annual Earned Income:$ _____ Last years Income:$ _____

Self Employed: Y or N Yes, Net Income? $_____

Monthly Benefit Amount:$ _____ or Maximum Available

Existing Coverage: Y or N (if yes answer questions below)

IDI Coverage: $ _____ Paid by: Employer or Employee

LTD Coverage: $ _____ Paid by: Employer or Employee

Percentage:_____% CAP/Max:_____

Is this replacement coverage: Y or N

Has insured ever been declined disability coverage: Y or N

If yes, year, carrier & reason: _____

Elimination Period: 30 60 90 180 360 720

Benefit Period: Age 65/67 60 months 24 months Lifetime

Mode of Payment: Annual Semi-Annual Quarterly Monthly

Premiums to be paid by: Employer or Employee

If employer (circle one) C-Corp S-Corp Partnership Sole Proprietorship

Riders: Residual COLA Future Purchase Option Other: _____

Own OCC Non-cancelable

Appointment Date, Time & Location: _____

If Business Owner as about Business Overhead expense DI? Ask about Supplemental Products: Colonial & Aflac?

Notes: