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Individual Disability Sheet

Name of Client: _____ DOB: _____

Tobacco use in past 12 months? Y-N Sex: Male _____ Female _____

Medical Conditions if Any? _____

Occupation of Client: _____

Annual Income: _____ or Monthly Income: _____

Benefits Requested

Base \$ Amount _____ Or Max \$ Amount _____

Supplemental Disability Income Requested \$ Amount _____

Years of Benefit: 1 2 5 to age 65 Elimination Period: 30 60 90 180 365

Riders: 5-year own occ _____ Benefit Increase _____

Age 65 own occ _____ Return of Premium _____

Hospital Benefit _____ Guarantee Insurability _____

Non-Cancelable _____ Residual Benefit _____