

Sample Disability Insurance Fact Finder

Name: _____

Gender: Male Female

DOB: ____/____/____

Smoker? Yes No

Mailing Address: _____

Occupation/Duties: _____

Preferred Contact: Phone: _____ - _____ - _____

E-Mail: _____

Last Year's Total Income (include W-2, K-1, and Retirement Plan): \$ _____

Are you covered by group disability insurance at work? Yes No

If so, % _____ Monthly Maximum Benefit \$ _____

Does your employer pay the cost? Yes No # of Employees: _____

Are you an owner? Yes No

Employer's Website: _____

Do you own any individual disability coverage now? Yes No

If Yes, amount: \$ _____ Elimination & Benefit Periods: _____

Do you have any current health diagnoses? _____

Current prescribed medications: _____

Please send proposals:

Via Employer

Fax # _____ - _____ - _____

E-Mail

Snail Mail