DISABILITY FACT FINDER

CLIENT PROFILE

To most effectively help find coverage options, we need to gather as much information as possible. Once completed, we will review all the information provided and begin formulating the most suitable recommendations available.

Date: _____

Name: _____ **DOB:** _____ **State:**_____ ☐ Male ☐ Female

Medical History: _____

_____

Company: ☐ Business Owner/Self Employed ☐ C corp **Total Employees?** _____ **Years in Business?** _____

Government Employee: ☐ Yes ☐ No **Branch:** ☐ Federal ☐ State ☐ County ☐ City **Years in Business?** _____

Gross Annual Income (W-2): _____ **- OR - Net Annual Income (Self Employed)** _____

Occupation: _____ **Work at Home?** ☐ Yes ☐ No **% of Time:** _____

Occupational Duties: _____

_____

Group LTD in Force? ☐ Yes ☐ No **Monthly Benefit:** _____ ☐ 60% ☐ 67%

Individual Coverage in Force? ☐ Yes ☐ No **Carrier?** _____ **Monthly Benefit:** _____

Is this a Replacement? ☐ Yes ☐ No **If yes, which policy?** ☐ Group LTD ☐ Individual Coverage

Who Will Pay the Premium? ☐ Employer ☐ Employee **Requested Monthly Benefit:** _____

Elimination Period: ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days ☐ 365 days

Benefit Period: ☐ 2yrs ☐ 5yrs ☐ To age 65 ☐ 66/67

Riders: ☐ SSIB _____ ☐ Residual Benefits ☐ COLA ☐ Non-cancelable ☐ ROP ☐ Own-Occ ☐ CAT _____

☐ Future Purchase Option ☐ Automatic Increase Benefit (AIB)

Critical Illness Amount: _____