Disability Quote Request

4800 Sugar Grove Blvd., Suite 350
Stafford, Texas 77477
Voice 713.977.0611 Fax 713-977-3877
life@affiliatedmarketing.com

PRODUCER INFORMATION:

Name _____ Date: _____

Phone:_____ **Fax:**_____ **E-mail:**_____

Address: _____

City:_____ **State:**_____ **Zip Code:** _____

Producers Social Security # _____

CLIENT INFORMATION:

Client Name _____ ☐ Male ☐ Female

Date of Birth:_____ **State Lives:**_____ **Works:**_____

Height(inches):_____ **Weight:**_____ **Tobacco Use:** ☐ Y ☐ N

Occupation:_____ **Title:**_____

Duties:_____

_____

Annual Salary: $_____ **Bonus: $**_____ **Unearned: $**_____

GOVERNMENT EMPLOYEE? Y ☐ **N** ☐

INDEPENDENT CONTRACTOR, SELF-EMPLOYED, OR BUSINESS OWNER? Y ☐ **N** ☐

NET INCOME: (AFTER EXPENSES) $_____ **WORKS FROM HOME? Y** ☐ **N** ☐

 # Of Years As Owner? _____ **If less than 1 full Year -** _____

Former Position /Duties: _____ **Former Salary: $**_____

Check one: C- Corp ☐ **S-Corp** ☐ **Partnership** ☐ **LLC** ☐ **# of Full Time Employees:** _____

INDIVIDUAL CASE DESIGN:

Benefit Amount: $_____**or MAX Premium Payer: Employer**_____**% Employee**_____**%**

Elimination Period(s): _____ **Benefit Period(s):** _____

Options: Partial/Residual_____ **Cost of Living** _____ **Future Purchase Rider:$**_____

Automatic Increase:_____ **Retirement Plan Deferral:$**_____

Other Requests: _____

_____

Disability Quote Request

Case Name: _____

BUSINESS OVERHEAD EXPENSE CASE DESIGN:

Monthly Expenses:$_____ Elimination Period:_____

Benefit Period: 12 Months☐ 18 Months☐ 24 Months☐ Other_____

Options:
Partial/Residual: _____ Future Purchase Option:_____ Professional Replacement: _____

Inforce BOE Coverage Amount:_____ Replacing? Y☐ N☐

COVERAGE IN-FORCE: *(check all that apply)*

Individual:☐ Group LTD:☐ Combination:☐ NONE☐

GROUP LTD: Carrier: _____ Replacement_____% Benefit Maximum $_____

Premium Payer: Employer_____% Employee _____%

Income Covered: Salary☐ Overtime☐ Bonus☐ Commissions☐ Retirement Contrib.☐

Benefit Amount: $_____ Waiting Period:_____ Benefit Period: _____

INDIVIDUAL DI: Carrier:_____ Benefit Amount $_____

Waiting Period:_____Benefit Period:_____Taxable Benefits? Y☐ N☐ Replacing? Y☐ N☐

Is there competition on the case?

_____

_____

Health Problems (Past 5 yrs.), Taking Medications (please list all current medications and dosage)?

_____

_____

_____

_____

_____

You may email or fax this form.
Fax 713.977.3877 Steve@affiliatedmarketing.com

Please contact us if you should have any questions at 713.977.0611