CLI

Mail to: support@clinsurancecenter.com

INDIVIDUAL DISABILITY PROPOSAL REQUEST

Agent Name:		Date:
Company:		Email:
Address:		Phone:
City/State:	Zip:	Fax:

PROPOSED INSURED INFORMATION

Client Name: _____ DOB: _____ Non-Smoker: How Long: _____

M / F Smoker: Cigarettes / Cigar / Chew/Weed

Income: Annual / Monthly $_____ Std / Substd _____

Occupation: _____ State Disability Coverage: Y / N

Specific Duties: _____ Existing Group LTD Coverage: Y / N

Specialty if M.D.: _____ If yes, Monthly Benefit $ _____

Existing Individual Coverage: Y / N

Employee Paid or ***Employer Paid*** If yes, Monthly Benefit $ _____

INDIVIDUAL PLAN OPTIONS

Plan Choices

Standard Insurance	***Guardian***	***Assurity***	***Ameritas***	***Principal***
Platinum Advantage	Provider Choice	AssurityBalance	DInamic Foundation	DI Solutions
5P 5A 4A 4P 3P 3A	6 6M 5 5M	Century+	6A 5A 4A 3A	5A 5AM 4A 4AM
2P 2A A B	4 4M 3 3M	4A 3A 2A 1A	2A A B	3A 3AM 2A A
	2 2M 1 1M		6M 5M 4M 3M	
Multi-Life Discount Y / N			2M M	

Waiting Period(s): 30 60 90 180 365 730

Benefit Period(s): 1 yr 2yr 5yr 10 yr Age 65 Age 67 Age 70 $_____

Monthly Benefit Amount(s):

Optional Riders

Supplemental Social Benefit: Y / N 60 90 180 365

(Must be 365 days if W-2 employee)

Monthly Benefit Amount:$_____

Non-Cancelable: Y / N

Residual Disability: Y / N

Catastrophic Benefit: Y / N

Cost of Living: Y / N

Future Purchase: Y / N

Own Occupation: Y / N

BUSINESS PLAN OPTIONS

Business Overhead Expense:

Waiting Period: 30, 60, 90 days _____

Benefit Period: 12 18 24 months

Benefit Amount: $_____

Future Purchase: Y / N Residual Disability: Y / N

# of employees (4 max) _____ (check guidelines)

# of owners _____

Buy-Sell:

Waiting Period(s): 12 18 24 months

Benefit Period: Lump Sum or Down Payment/ Monthly – 2, 3, or 5 years

Benefit Amount: $_____

Extended Benefit: Y / N Future Buy-Out: Y / N

Confidential Personal Questionnaire for Disability Protection

AGE	30	35	40	45	50	55
Odds of Disability*	42%	41%	39%	36%	33%	27%
Average Duration**	5.1 Years	5.1 Years	6.6 Years	6.6 Years	5.6 Years	3.8 Years

*1985 CIDA Table, ** 1985 Society of Actuaries DTS Odds and length of disability 90 days or longer prior to age 65

Client Name _____

Date of Birth _____

1. If your disability were "average", how much would it cost you in lost wages? $ _____

Disability insurance is underwritten like a health plan; May I ask some health questions?

2. Do you manage any **health conditions**?
3. Do you take any **medications**?
4. Have you ever been **injured or hurt**?
5. Have you used **tobacco products** in the last year?
6. Tell me what you do during "**a day at the job**"? Do you have a **specialty**?
7. What are the **physical requirements** and **tools** you use?
8. Are you an **employee** or **self-employed**? If **self-employed**, how long?
9. Do you **work from home**? If yes, **more than 60%** of the time?
10. Is this the **only work** you do?
11. Does your **job require traveling**? If Yes, How much? How long?
12. Are you eligible for any **other disability protection** at work?
13. Do you fly as a **pilot**, **race cars**, **scuba dive** or do **any hazardous activity**?
14. What do you declare to the **IRS** as your **income after business expenses?**