INDIVIDUAL DISABILITY INCOME INSURANCE

FACT FINDER

Advisor ______________________________________ Date_________________

Advisor Phone Number _______________________________ Email Add: ___________________________

Client's Name ___________________Phone #___________________Email _____________________

Date of Birth ___________Male/Female_______ Height/Weight ______________

Tobacco: ☐ Never ☐ Used In Past-Date Quit_________ ☐ Current ☐ Type Used or Using______

Occupation________________________________ Years in Current Occupation ______________________

Duties____

Work from Home Yes/No Percent of Duties outside of Residence_____%

Annual Earned Income:

Salaried/Hourly Employee (W2, Payroll Stub, IRS 1040) $_________________________

Self Employed/Business Owner: Net Business Income (Schedule C, K-1) $____________

If Business Owner: % Owned _____ Years Owned _____ # Full Time Employees _____

Business Type: ☐ C-Corp ☐ S-Corp ☐ LLC/LLP ☐ Sole Prop ☐ Partnership

Existing Individual DI Coverage: Monthly Benefit Amount ___________ Benefit Period ___________

Existing Group DI Coverage: % of Income ________ Cap: _____ Employer Paid Yes/No

Replace or Add to Existing Coverage ___________

Medical Information:

1. In the past 10 years have you applied for, received or been denied disability benefits for Workers Compensation, Social Security or any other disability insurance? Yes/No

2. Have you had, been told, been treated or diagnosed as having anxiety, depression, nervousness or stress, or other emotional or psychiatric disorder? Yes/No

3. Have you had, been told, been treated or diagnosed as having back or neck pain, sciatica, arthritis or any other disease, disorder or injury of the bones, joints, nerves or muscles? Yes/No

4. Have had any other medical condition or history for which you have had surgery, been hospitalized, take medication for, seen by a physician or chiropractor for in the last 3 years. Yes/No

Medications currently taking ____

Details to "Yes" answers above ____

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