INDIVIDUAL DISABILITY INCOME INSURANCE
FACT FINDER

CLIENT'S NAME_____DATE OF BIRTH _____ MALE/FEMALE_____

TOBACCO USE: ☐ Never Used
☐ Currently Use, Type _____
☐ Used in the past-Quit Date_____

OCCUPATION _____ YEARS IN CURRENT OCCUPATION_____

DUTIES_____

WORK FROM HOME Y/ N_____ PERCENT OF DUTIES OUTSIDE OF RESIDENCE_____%

ANNUAL EARNED INCOME:

Salaried/Hourly Employee Income (W-2) $_____

Self Employed/Business Owner Net Business Income (Schedule C, K1) $_____
If Business Owner: % Owned_____ Years Owned_____ # Full Time Employees_____
Business Type (C-Corp, S-Corp, LLC/LLP, Partnership, Sole Prop)_____

EXISTING DI COVERAGE Yes/No_____
Existing Individual DI Coverage: Monthly Benefit Amt $_____ Benefit Period_____
Existing Group DI Coverage: % of Income_____ Cap $_____ Employer Paid Y/N_____
Replace or Add to Existing Coverage_____

MEDICAL HISTORY:

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? Y/N_____

2. Have you had, been told, been treated or diagnosed as having anxiety, depression, nervousness or stress, or other emotional or psychiatric disorder? Y/N_____

3. Have you had, been told, been treated or diagnosed as having chronic back or neck pain, sciatica, arthritis or other disease, disorder or injury of the bones, joints, nerves or muscles? Y/N_____

4. Have you had any other medical condition or history for which you have had surgery, been hospitalized, take medication for, seen by a physician or chiropractor in the past 3 years? Y/N_____

5. Medications currently taking_____

DETAILS TO YES ANSWERS ABOVE_____

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