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# Request for Disability Income Proposal

## AGENT INFORMATION

Name: \_\_\_\_\_ Affiliation: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_ Email: \_\_\_\_\_ Website: \_\_\_\_\_

## CLIENT and PROPOSAL INFORMATION

### Individual or Multi-Life Disability Income

**Client:** \_\_\_\_\_ Date of Birth: \_\_\_\_\_  Male  Female  Tobacco  Non-Tobacco  Employee  Self-Employed State of Issue: \_\_\_\_\_  
 Annual Income: \$ \_\_\_\_\_ Monthly Benefit Wanted: \$ \_\_\_\_\_ Existing Monthly DI Coverage: Individual \$ \_\_\_\_\_ Group \$ \_\_\_\_\_  
 Occupation and Duties: \_\_\_\_\_ Who Will Pay for New Policy: \_\_\_\_\_

**Elimination Period:**  30  60  90  180  365  730 **Benefit Period:**  2 yr  5 yrs  to age 65  to age 70  lifetime **Riders:**  Cost of Living Adjustments  
 Residual Disability  Guaranteed Insurability  Catastrophic Disability  Non-Cancelable  Own Occupation  Return of Premium  LTC-Guaranteed Purchase Option

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