

new west insurance

A Principal Office of Insurance Designers

Disability Quote Request

Client Information

Name: _____ DOB _____ Age: _____

Sex: Male / Female Tobacco Use: Yes / No Resident State: _____ Work State: _____

Net Annual Income: Salary: \$ _____ Bonus (2 yr. avg.): \$ _____

Occupation: _____

Job Description/Duties: _____

Business Owner: Yes _____ No _____

If Yes, check one: C-Corp _____ S-Corp. _____ LLC / Partnership _____ Sole Proprietor _____

Number of Employees: Full Time: _____ Part Time: _____ Years in Business: _____

Group DI Inforce: _____ Taxable Benefits: Yes _____ No _____ Carrier: _____

Indiv DI Inforce: _____ Taxable Benefits: Yes _____ No _____ Carrier: _____

Medical Conditions: _____

Medicine (Name, Dosage): _____

Individual Policy Information

Monthly Benefit: Base: \$ _____ SIS: \$ _____ Retirement: \$ _____

Premium Payer: Employee ___ Employer ___ Waiting Period: 7 / 30 / 60 / 90 / 180 / 365 days

Benefit Period: 3 mos / 6 mos / 1 yr / 2 yrs / 5 yrs / age 65 / age 67 / age 70 /

Lifetime Riders: Residual / COLA / Guaranteed Insurability / CAT / Transitional Your Occ /
Own Occ

Other Information: _____

Business Overhead / Buy-Sell / Business Protector

Ownership %: _____ Monthly Expenses: \$ _____

Business Value: \$ _____ Loan Amount: \$ _____

<u>BOE</u>	<u>DBS</u>
Benefit Monthly: \$ _____	Lump Sum: \$ _____ Monthly: \$ _____

Waiting Period: 30 / 60 / 90 days	Waiting Period: 365 / 540 / 730 days
Benefit Period: 12 / 18 / 24 months	Benefit Period: 2 yrs / 3 yrs / 5 yrs / Lump Sum