DISABILITY PROPOSAL REQUEST

CLIENT PROFILE:

Name: ______________________ Gender: ________ DOB: ____________ State: ___________

Height: _______ Weight: _____ Smoker (Y/N): ___ If Y, Type: ________________ Date of Last Use: _____________

Current Medication(s) – Please Include Name and Reason(s) for Use: ______________________

____

____

Medical History (Hospitalizations, Conditions, Diseases, Health Concerns - Include Date of Diagnosis):

____

____

U.S. Citizen (Y/N): __________ If N, VISA/Green Card Status: ______________________

Insurance Declines (If Any - Include Date, Reason and Carrier): ______________________

OCCUPATION & INCOME DETAILS:

Occupation: ______________________ Specialty (If Any): ______________

Brief Job Description/Duties: ______________________

W2 or Adjusted Gross Income: ________________ Bonus (If Available): ___________ Years in Business: _______

Business Owner (Y/N): ___ If Y, Ownership Percentage: ______ Type of Corp.: ________ # of Employees: ______

IN-FORCE DETAILS:

Group or Individual Disability: ______________________ Monthly Benefit Amount: ______________________

ADDITIONAL NOTES: ______________________

____

____

COVERAGE OPTIONS:

Monthly Benefit Amount: ______________________

BENEFIT PERIOD:

- ☐ 2 Years
- ☐ 5 Years
- ☐ 10 Years
- ☐ To Age 65
- ☐ To Age 67/70

ELIMINATION PERIOD:

- ☐ 30 Days
- ☐ 60 Days
- ☐ 90 Days
- ☐ 180 Days

RIDERS:

- ☐ Own Occupation
- ☐ Future Increase Option
- ☐ Cost of Living (COLA)
- ☐ Residual
- ☐ Catastrophic (CAT)

AGENT INFORMATION:

Name: ______________________ Agency: ______________________

Contact #: ______________________ Email: ______________________

SUBMIT THE COMPLETED FORM VIA EMAIL

individuallife@savoyassociates.com

QUESTIONS? ASK OUR INDIVIDUAL LIFE TEAM

516.390.2710