Date: _____ / _____ / _____   ***Broker Quote Request Form*** | Sent _____ / _____ / _____ EM - Fax - Mail |

Broker Name: _____   **Phone:** _____   **Email:** _____

Client Name: _____   **DOB:** _____   M - F   N/S – Smkr,   **Best – Pref – Stan**
Rtd Tbl: _____

Known Medical Conditions:
_____

Life:

Death Benefit	Plan Type	Carrier	Premium Design

Disability: (Current DI Mo. Benefit: $ _____ (Indv - Group) Company: _____)

Carrier	Plan Type	Monthly Benefit	Elim Period	Benefit Period	Riders
	DI / BOE / Buy Sell		60 / 90 / 180		SSS / COLA / Residual / FIO:
	DI / BOE / Buy Sell		60 / 90 / 180		SSS / COLA / Residual / FIO:
	DI / BOE / Buy Sell		60 / 90 / 180		SSS / COLA / Residual / FIO:

Additional Questions for <u>Disability Coverage</u>:

1) **Employment Type:**

   If Employee: YTD W-2 Income: $_____   Last Yr: $_____   Yrs at Job:_____

   If Self-Employed: YTD Income: $_____   Last Yr: $_____   Yrs at Job:_____

2) **Job Title:** _____   **Adv. Degrees:** _____   **Specialty:** _____

   Exact Duties and **% Time Spent** on each**:** _____

3) **If working from Home:** Do you have clients come to your home or do you go out to see clients on a regular basis? Y N
   If yes, how often or what % of time: _____

LTC: <u>Client</u> DOB: _____ (Pref – Select),   <u>Spouse</u> DOB: _____ (Pref – Select)

Carrier	Daily/Mo Benefit	Elim Period	Benefit Period	Pay Option	Riders
				Life / 10 / Single	
				Life / 10 / Single	

Notes: _____

(Date) _____

_____

_____