

DIS Proposal Request Form

Quotes within 24 hours guaranteed!

Print and fax completed form to 619-325-8444
or e-mail to sales@diservices.com

Broker Information

Today's date:	Phone:	Fax:
Broker name:		Affiliation:
Address:		
City:	State:	Zip:
E-mail or FAX to:		

Client Information

Client name:	DOB:		
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Tobacco user: <input type="checkbox"/> Yes <input type="checkbox"/> No	State:	Net annual income:
Occupation:	Work at home: <input type="checkbox"/> Yes <input type="checkbox"/> No	% of time	
Company: <input type="checkbox"/> Business owner / Self employed <input type="checkbox"/> C-corp	# of employees:	Years in business:	
Government employee? <input type="checkbox"/> Yes <input type="checkbox"/> No	Years of government employment:	<input type="checkbox"/> Federal <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City	
Group LTD in force? <input type="checkbox"/> Yes <input type="checkbox"/> No	Monthly amount: \$	<input type="checkbox"/> 60% <input type="checkbox"/> 67%	Employer paid: <input type="checkbox"/> Yes <input type="checkbox"/> No
Individual coverage in force: <input type="checkbox"/> Yes <input type="checkbox"/> No	Monthly amount: \$	To remain in force? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Occupation duties:			
Medical issues or other comments:			

Individual Disability Policy

Who will pay the premium? <input type="checkbox"/> Employer <input type="checkbox"/> Employee	Monthly benefits: \$
Elimination period: <input type="checkbox"/> 60 <input type="checkbox"/> 90 <input type="checkbox"/> 180 <input type="checkbox"/> 365	Benefit period: <input type="checkbox"/> 2 yrs <input type="checkbox"/> 5 yrs <input type="checkbox"/> to age 65 <input type="checkbox"/> 66/67
Benefit riders: <input type="checkbox"/> SSIB _____ <input type="checkbox"/> Residual benefits <input type="checkbox"/> COLA <input type="checkbox"/> Non-cancelable <input type="checkbox"/> Return of premium <input type="checkbox"/> CAT _____	
<input type="checkbox"/> Own Occ. <input type="checkbox"/> Future purchase option <input type="checkbox"/> No riders	

Overhead Expense Policy

Monthly benefit: \$	Elimination period: <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90	Benefit period: <input type="checkbox"/> 12 mos <input type="checkbox"/> 18 mos <input type="checkbox"/> 24 mos
Benefit riders: <input type="checkbox"/> Residual benefits <input type="checkbox"/> Future purchase option		

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DIS™ Disability
Insurance
Services

Real expertise by real experts.