Disability Intake Form

Personal Information

First/Last Name: DOB:

Gender: State: Nicotine Usage:

Employer

City/State:

Job Title and Daily Obligations:

For Sales- % of time in sales/travel/supervision:

For Bus. Owner- how long in ownership, and how many employees:

If physician/medical specialist or resident/student- Name and Address of Employer:

If dental/medical resident or student, also provide year of study/graduation year:

Annual Gross Income

Base Salary:

Commission/Bonus:

Existing Disability Income Insurance

Short or Long-term Group?

Percentage/amount of salary: Who is premium paid by: Company or Self?

Plan Information

Waiting period: 60/90/180 days?

Benefit Period: 2/5/10 years? Or to specific age?

Specific coverage amount requested:

Additional Notes: