Elite Marketing Group
An Insurance Designers member since 1986

DISABILITY INCOME QUOTE REQUEST FORM

Full Name: _____ DOB / Age: _____ City / State: _____

☐ Male ☐ Female ☐ Smoker ☐ Non-Smoker ☐ Tobacco Use

Occupation (Industry and Exact Duties):
_____
_____
_____

Any Manual Duties?
_____
_____
_____

Number of years in occupation:
_____

Does client work out of home?
☐ Yes _____ % of time
☐ No

If Business Owner, how long?
_____

Annual or Monthly Income (Gross earnings minus business expense):
_____

Income last year: _____
Income 2 years ago: _____

Any known medical or other underwriting concerns?
(Counseling and chiropractic are relevant)
_____
_____

Currently on any medication?
If so, please list name and dosage of medication:
_____
_____

Elimination Period:
☐ 30 ☐ 60 ☐ 90 ☐ 180 ☐ 365 days

Benefit Period: ☐ 2 years ☐ 5 years ☐ 10 years ☐ To age 65 ☐ to age 67 ☐ to age 70

Riders:
☐ Social Security Substitute ☐ COLA ☐ Catastrophic Benefit Rider
☐ Residual / Partial Disability ☐ Automatic Increase ☐ Own Occ.
☐ Return of Premium ☐ Future Increase ☐ Transitional Own Occ.

Purpose: ☐ Individual Disability Income ☐ Business Overhead Expense (Monthly expenses) $_____ ☐ Buy / Sell

Existing Disability In Force:
Individual DI $ _____ Company _____
Group DI _____ % of salary up to $ _____
☐ Taxable (employer paid) ☐ Non-Taxable (employer paid)

Agent Name
_____
_____

E-mail, Fax or Mailing Address to send proposals:
_____
_____

Send completed form to Kristy Fulton – kfulton@elitemktg.net or Fax to 713-574-2756, call with questions 713-507-1035 or Paul Davis – pdavis@elitemktg.net or Fax to 512-257-9701 call with questions 512-900-4591.
Unless otherwise specified, quote will be run with maximum possible disability benefit based on occupation, income and with all available riders.
Where available, an alternate premium report will also be included to help you determine appropriate mix of benefits and riders.