



**Disability Income Insurance Proposal Request**

Email or Fax Completed Form

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Fax: 706-320-3848

**Client Information:**

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Tobacco Status: \_\_\_\_\_

Health Conditions/Medications: \_\_\_\_\_

Self Employed:  Yes  No If Yes, How Long? \_\_\_\_\_ State of Sale: \_\_\_\_\_

Annual Income: \_\_\_\_\_ Occupation and Duties: \_\_\_\_\_

**POLICY INFORMATION:** Complete the appropriate section(s)

	LONG-TERM DISABILITY INCOME (LTDI)	SHORT-TERM DISABILITY INCOME (STDI)	
BENEFIT AMOUNT:	<input type="checkbox"/> MONTHLY \$ _____ or <input type="checkbox"/> MAX	<input type="checkbox"/> MONTHLY \$ _____ or <input type="checkbox"/> MAX	
BENEFIT PERIOD:	<input type="checkbox"/> 2YR. <input type="checkbox"/> 5YR. TO AGE: <input type="checkbox"/> 65 <input type="checkbox"/> 67 <input type="checkbox"/> 70	<input type="checkbox"/> 3 MO. <input type="checkbox"/> 6 MO. <input type="checkbox"/> 12 MO. <input type="checkbox"/> 24 MO.	
ELIMINATION PERIOD:	<input type="checkbox"/> 60 <input type="checkbox"/> 90 <input type="checkbox"/> 180 <input type="checkbox"/> 365 (DAYS)	<input type="checkbox"/> 0/7 <input type="checkbox"/> 7 <input type="checkbox"/> 0/14 <input type="checkbox"/> 14 <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 (DAYS)	
RIDERS/OPTIONS:	<input type="checkbox"/> SOCIAL INSURANCE SUPPLEMENT <input type="checkbox"/> AUTOMATIC INCREASE <input type="checkbox"/> FUTURE INCREASE <input type="checkbox"/> RESIDUAL <input type="checkbox"/> COLA <input type="checkbox"/> CATASTROPHIC <input type="checkbox"/> RETURN OF PREMIUM <input type="checkbox"/> 50% <input type="checkbox"/> 80% <input type="checkbox"/> TRUE OWN OCCUPATION	<input type="checkbox"/> HOSPITAL CONFINEMENT <input type="checkbox"/> CRITICAL ILLNESS <input type="checkbox"/> RETURN OF PREMIUM <input type="checkbox"/> 50% <input type="checkbox"/> 80%	
	OVERHEAD EXPENSE	BUY-SELL	KEY PERSON
BENEFIT AMOUNT:	MONTHLY \$ _____	LUMP SUM \$ _____ MONTHLY \$ _____ <input type="checkbox"/> COMBINE BOTH	LUMP SUM \$ _____ OR LUMP/MONTHLY \$ _____
BENEFIT PERIOD:	<input type="checkbox"/> 12 MO <input type="checkbox"/> 18 MO <input type="checkbox"/> 24 MO	<input type="checkbox"/> 24 MO <input type="checkbox"/> 36 MO <input type="checkbox"/> 60 MO	
ELIMINATION PERIOD:	<input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 (DAYS)	<input type="checkbox"/> 365 <input type="checkbox"/> 540 <input type="checkbox"/> 730 (DAYS)	<input type="checkbox"/> 90 <input type="checkbox"/> 180 <input type="checkbox"/> 365 <input type="checkbox"/> 730 (DAYS)
RIDERS/OPTIONS:	<input type="checkbox"/> RESIDUAL <input type="checkbox"/> FUTURE INCREASE <input type="checkbox"/> BUSINESS LOAN	<input type="checkbox"/> FUTURE INCREASE	

**ADDITIONAL INFORMATION:** \_\_\_\_\_

Visit our Website at [www.cunninghaminsuranceinc.com](http://www.cunninghaminsuranceinc.com) for additional sales tools.