Business Expense Disability Quote Request

Agent/Broker Name: _________________________State: _______Date: ____________

Insured Name: __________________________________ State: ______ DOB: ___________

Height: _______ Weight: ________ Tobacco Use: *Yes / No*

Occupation: ____

Employer: ________________________________ Monthly Gross Income: __________

For Self-Employed Only:

- Length of self-employment: ________
- Work out of home? *Yes / No* If yes, approximately what percentage of time? ____
- Last year's Tax Schedule C income (net income): ___________

Other BE insurance in force? *Yes / No*

- To be replaced? *Yes / No*
- Details of current plan: ____

Any significant health history, conditions, or recoveries? ___________________________

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Plan Information:

Monthly Benefit: ___________ (total amount of qualifying monthly business expenses)

Benefit Period: *12 months* *18 months* *24 months*

Waiting Period: 30 days 60 days 90 days

Optional Riders:

§ Business loan protection: Loan amount: ___________

Monthly payment: ___________ Loan duration: ____________

§ Future purchase

Other information: ____

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Fax to: 414-427-8330, or call John, Debbie, or Mike at 414-427-8660