CPS Horizon Financial
Key Person Disability Quote Request

Agent/Broker Name: _____State: _____Date: _____

Insured Name: _____ State: _____ DOB: _____

Height: _____ Weight: _____ Tobacco Use: *Yes / No*

Occupation: _____

Employer: _____ Monthly Gross Income: _____

Other key person disability insurance in force? *Yes / No*

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

Any significant health history, conditions, or recoveries? _____

_____

Plan Information (2-part benefit or just lump sum benefit):

1. Monthly Benefit Amount (optional): _____ Elimination Period: 90 or 180 days (*circle one*)

2. Lump Sum Benefit Amount (pays out after the initial monthly benefits): _____

Elimination Period for the lump sum benefit: 180, 365, or 730 days (*circle one*)

Other information: _____

_____

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