



Life, Long Term Care, Disability, Annuities, Living Benefits

Long-Term Disability Income 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 DI insurance in force? Yes / No

- If yes, Group or Personal?
• To be replaced? Yes / No
• Details of current plan: _____

Any significant health history, conditions, or recoveries? _____

Plan Information:

Monthly Benefit: _____ Waiting (Elimination) Period: _____

Benefit Period: 2 years 5 years to age 65 to age 67 to age 70

Riders:

- COLA Social Security Integration
Residual Benefit Future Purchase
Non-Cancelable Own Occupation
Return of Premiums Critical Illness
Catastrophic Disability (LTC) Other _____

Other information: _____

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