CPS Horizon Financial

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

Short-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: _____ Benefit Period: *3 mos.* *6 mos.* *1 year* *2 years*

Waiting Period: _____(injury/illness – *circle one of the following*):
0/7 days *7/7 days* *0/14 days* *14 days* *30 days* *60 days* *90 days*

Riders:

Critical Illness *Hospital Confinement Indemnity*

Return of Premiums *Accident Medical Expense*

Other information: _____

_____

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