

# DIS Proposal Request Form

Quotes within 24 hours

## Broker Information

Today's date: \_\_\_\_\_ Phone: (800)205-8400 Fax: (949)720-1489

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Broker name: BEACH CITIES INSURANCE- Affiliation: \_\_\_\_\_

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Address: P.O. BOX 185

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City: CORONA DEL MAR State: CA Zip: 92625

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E-mail or FAX to: bryan@beachins.com or (949)720-1489

## Client Information

Client name: \_\_\_\_\_ DOB: \_\_\_\_\_

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Sex:  M  F Tobacco user:  Yes  No State: \_\_\_\_\_ Net annual income: \_\_\_\_\_

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Occupation: \_\_\_\_\_ Work at home:  Yes  No % of time \_\_\_\_\_

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Company:  Business owner / Self employed  C-corp # of employees: \_\_\_\_\_ Years in business: \_\_\_\_\_

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Government employee?  Yes  No Years of government employment: \_\_\_\_\_  Federal  State  County  City

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Group LTD in force?  Yes  No Monthly amount: \$ \_\_\_\_\_  60%  67% Employer paid:  Yes  No

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Individual coverage in force:  Yes  No Monthly amount: \$ \_\_\_\_\_ To remain in force?  Yes  No

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Occupation duties: \_\_\_\_\_

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Medical issues or other comments: \_\_\_\_\_

## Individual Disability Policy

Who will pay the premium?  Employer  Employee Monthly benefits: \$ \_\_\_\_\_

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Elimination period:  60  90  180  365 Benefit period:  2 yrs  5 yrs  to age 65  66/67

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Benefit riders:  SSIB \_\_\_\_\_  Residual benefits  COLA  Non-cancelable  Return of premium  CAT \_\_\_\_\_  
 Own Occ.  Future purchase option  No riders

## Overhead Expense Policy

Monthly benefit: \$ \_\_\_\_\_ Elimination period:  30  60  90 Benefit period:  12 mos  18 mos  24 mos

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Benefit riders:  Residual benefits  Future purchase option

