

Disability Quick Quote Form

Agent Name: _____ Agent Phone: _____

Agent Email: _____

Client Name: _____ Date of Birth: _____
State: _____ Gender: ☐ Male ☐ Female

Tobacco Use: ☐ Yes (Type: _____) ☐ No Height: _____ Weight: _____

Does the client have any medical history such as arthritis, fibromyalgia, cancer, back/spine problems, including Chiropractic care, heart or circulatory trouble, depression/anxiety, diabetes or any major surgeries? **Include details of all health issues/surgeries along with medications:** (date of diagnosis – dosage and frequency of medication)

Occupation/Daily duties _____

Work 30+ hours per week? ☐ Yes ☐ No **Work from home:** ☐ Yes - percentage of time: _____ % ☐ No

Self-employed: # of Years _____ Number of full time Employees _____

Net Annual Income \$ _____ Prior Year \$ _____

Employee: # of Years _____ **Gross** Annual Income \$ _____ Prior Year _____

List any existing disability coverage whether individual or through an employer:

Please provide a quote for:

Benefit Amount - ☐ Maximum Available (60% of annual income) &/or Specific Amount: \$ _____

Elimination Period: ☐ 30 ☐ 60 ☐ 90 ☐ 180 ☐ 365

Benefit Period: ☐ To age 65/67 ☐ 60 months ☐ 24 months ☐ 12 months

Not all elimination and benefit period options are available in every state or with all carriers. The proposal will include available options.

A proposal will be based on the information you provide on this quote form. The proposal is not an offer of coverage but rather an estimate of what an underwriting decision may be based on limited information provided. All underwriting offers are tentative and subject to medical and financial review.

Phone / Text: 704-200-3124

email: Leon@sentryincomeprotection.com

<http://www.sentryincomeprotection.com/quickquote>

THANK YOU FOR YOUR BUSINESS!