



isn network

Putting the service into financial services.

1525 Faraday Avenue, Suite 180
Carlsbad, CA 92008
800-338-1892
760-930-9495 Fax
www.teamisn.com

Today's Date: Telephone #: Fax #:

Broker Name: Affiliation:

Address: Suite #:

City: State: Zip Code:

Is this your first DIS proposal? YES NO Email Address:

Illustration to be received by: Mail / Fax / Email

CLIENT INFORMATION

Client Name: D.O.B.:

Sex: M F Tobacco user: Y N State: Net Annual Income:

Occupation:

Job Description/Duties:

Business Owner / Self Employed Y N C-Corp Y N # of employees: # of years in business:

Group LTD in force? Y N Monthly Amount: \$ 60% or 67% (Circle One)

Individual coverage in force: Y N Monthly Amount: \$ To remain in force? Y N

Medical Issues or Other Comments:

(please use more pages if needed)

INDIVIDUAL DISABILITY POLICY

Who will pay the premium: Employer Pay Employee Pay

Monthly Benefit \$:

Elimination Period: 60 90 180 365 730

Benefit Period: 2 Years 5 Years To Age 65 66/67 Lifetime

Benefit Riders: SSIB Residual Benefits COLA Non-Cancelable
Return of Premium Own Occ. No Riders Future Purchase Option

OVERHEAD EXPENSE POLICY

Monthly Benefit \$:

Elimination Period: 30 days 60 days 90 days

Benefit Period: 12 months 18 months 24 months

Benefit Riders: Residual Benefits Future Purchase Option Return of Premium