isn network
Putting the service into financial services.

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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