FROM: _____ TO: _____

DI SALES DESK
Phone: 888.841.3045 Fax: 847.674.0402 Email: di@mgaprt.com

(RFP) Request for Proposal: DISABILITY INSURANCE

***** Please complete and submit pages 1 & 2 of this form. *****

Date_____ **Need by:**_____ **Return via Mail**____ **Email**____ **Fax**_____

Producer's name: _____ **Phone**:_____ **Fax**:_____

Email:_____ **Mailing Address**:_____

Client:_____

M ☐ F ☐ **Date of Birth** :_____ **TOBACCO**: NO ☐ YES: ☐ Type_____

State where Client lives:_____ **State where app will be signed**:_____

►Page 2 of this form [Pre-screening issues] must be submitted for an accurate proposal.

Current In-force Coverage Amount: $_____ **Current** Type: Individual ☐ Group ☐ Paid by?:_____

Occupation: _____ Exact Duties: _____

Personal taxable earned Income on last year's tax return:_____ Has this been consistent for several years?_____

Percent of: _____Admin. _____Manual _____Supervisory (over whom?)_____

Business Owner or Self Employed? **Yes** ☐ **No** ☐

If yes: Percent ownership_____ How long as owner? _____

Type of Business Entity:

Sole Proprietor ☐ Partnership ☐ S Corp ☐ C-Corp ☐

Number of Employees in firm: _____ How old is this business: _____

For all W-2 employees:

Private Sector? ☐

Public Sector? ☐

[Federal, State, County, Municipal, Local]

How Many Years_____

Policy types: Individual Disability Income ☐ Business Overhead Expense ☐ Disability Buy Out ☐
Key-Person Replacement ☐ Business Loan Protection ☐ Retirement Savings Protection ☐

Individual Disability Income:

Desired Monthly Amount or Maximum_____

Elimination Period (days): 30 ☐ 60 ☐ 90 ☐ 180 ☐ 365 ☐ 730 ☐

Benefit Period: 2 year ☐ 5 year ☐ Age 65 ☐ Age 67 ☐ Age 70 ☐ Lifetime (if available) ☐

Optional Riders: Residual ☐ Future Purchase Option ☐ COLA ☐ Non-can ☐ Other: _____

Business Overhead Expense:

Monthly Amount(s): _____ **Elimination Period**:(days) 30 ☐ 60 ☐ 90 ☐

Benefit Period: 12 months ☐ 18 months ☐ 24 months ☐ 30 months ☐

Optional Riders: Residual ☐ Future Purchase Option: ☐ Other: _____

Has a certain premium been budgeted or planned? _____

Special Requests? _____

Questions for Pre-Screening Disability Insurance Products

1. Describe the occupation and the exact duties.

   _____

2. Where is the work performed? office at home, office away from home, lab, in the field, at client's work site, etc.

   _____

3. Other activities, hobbies, or avocations that might be considered hazardous (work-related and/or recreational)? [SCUBA, racing, climbing, flying, etc.]

   _____

4. If self employed:
   a. How long? _____
   b. Percent ownership? _____
   c. Number of employees? _____

5. Is ratio of height and weight normal?

   _____

6. Any significant medical history, chiropractic visits? Surgeries (past or planned)?

   _____

7. List all medications:

   _____

8. Any current or past treatment (medication and/or counseling) for depression, anxiety stress, or any other mental/nervous history?

   _____

9. Amount of taxable/earned/documented income reported on last year's tax return?

   _____

10. Is there any current group Long Term Disability (LTD) or any individual Disability Income (DI) in force? Please specify how much monthly benefit of each.

    _____

    a. Do you want to replace current coverage? _____
       1. Show same amount? _____
       2. Show maximum amount? _____
    b. Do you want to show the additional amount, keeping current coverage? ____

11. Any other comments, underwriting concerns, other details?

    _____