

Disability Insurance Quote Request Form



Fax to: Ash Brokerage Disability Team (260) 478-3900
Scan and Email to: DIquotes@ashbrokerage.com

Advisor Name: _____

Advisor Phone: (_____) _____ E-mail: _____

Address: _____

Client Name: _____ M F DOB: _____ State: _____

Tobacco Use Nicotine Use Marijuana Use Cessation Products None

Very Important: Over 40% of disability cases are rated, declined or carry exclusions. Eliminate the surprise for your client and increase your closing percentage by asking your client about any known health conditions. Specifically ask if they have a history of:

Neck or back disorders: Yes No

Depression, anxiety or other mental disorders: Yes No

Diabetes: Yes No

Sleep Apnea: Yes No

Cardiac conditions: Yes No

Cancer: Yes No

Other known health conditions for which lengthy treatment was needed: Yes No

Please provide details to any yes answers: _____

Height/Weight: _____ Current medications and length of time on each: _____

Occupation: _____

Daily duties - please be specific: _____

Time at current employer: _____

Government employee? Yes No Work from home? Yes No

Business owner? Yes No If business owner or in management, how many full-time employees? _____

If self-employed, how long? _____ Monthly Business Expenses: _____

Current gross earnings (after expenses if self-employed): \$ _____

Last year: \$ _____

Two years ago: \$ _____

Existing Group Disability Insurance: Monthly amount or % of income _____ EP _____ BP _____

Existing Individual Disability Insurance: Monthly amount \$ _____ EP _____ BP _____

Will it be replaced? Yes No

Coverage Amount Desired: _____ or Max Benefit Amount

Desired Elimination Period (check one): 30-day 60-day 90-day 180-day 365-day

Desired Benefit Period (check one): 2-yr 5-yr To Age 65 Maximum Available

Optional Riders (if available): Residual (Partial) COLA Catastrophic

Guaranteed Insurability Option Return of Premium Own Occupation/Transitional Own Occ