



Insurance | Risk Management | Consulting

DISABILITY INCOME FACT FINDER

To help you obtain competitive disability insurance quotes, please provide information on your earned income, medical history and other factors that may impact underwriting. This is not an actual application for insurance and does not guarantee any coverage will be offered. This information is held confidential and released only to parties named below.

Date: _____

CLIENT INFORMATION

Name: _____ Age: _____ Date of Birth: _____ Sex: M F
 Do you use tobacco products? Yes No State of Residence: _____
 Occupation: _____
 Exact Duties: _____
 Number of Years in Occupation: _____ Prior Occupation (if recently changed): _____
 If a Business Owner, Number of Employees: _____ % of Ownership: _____

EARNED INCOME

Employment Status	Verification Needed with Application	Current Year	Prior Year
Non-Owner Employee Salary and Bonus	Form W-2/Current Pay Stub with YTD	\$	\$
Owner Employee C or S Corp.	Form W-2/Current Pay Stub with YTD	\$	\$
Owner Employee C or S Corp.	Form 1120 or Form 1120S	\$	\$
Sole Proprietor	Form 1040 (Schedule C)	\$	\$
Share of Partnership	Form 1040 (Schedule E or K-1)	\$	\$
Pension/Profit Sharing/401(k)	Contribution that would end if you became disabled	\$	\$
Other Earned Income		\$	\$
	TOTAL:	\$	\$

UNEARNED INCOME NET WORTH

Do you have annual unearned income (e.g. dividends, interest) that exceeds 10% of earned income, or does your net worth exceed \$6 million?
 Yes No If yes, please provide details (actual net worth, actual unearned income and sources).

EXISTING COVERAGE

Group LTD: 60% 67% Maximum Benefit of \$ _____ /per month
 Premiums Paid By: Employer Employee
Individual Coverage: Monthly Benefit \$ _____ Carrier: _____

Woodland Hills, CA
800.473.5966

East Hartford, CT
860.289.7732

Fairfield, CT
800.653.1322

Coral Springs, FL
954.486.1236

Rolling Meadows, IL
630.285.3742



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MEDICAL INFORMATION

Do you have a history of:

High Blood Pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Fatigue	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Thyroid	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Stress	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Circulatory Conditions	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Anxiety	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Tumors	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Blood/Protein in Urine	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Depression	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Cyst	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Mental/Nervous Condition	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Bones/Joints/Skin	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Back/Neck	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Respiratory	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Height: _____ **Weight:** _____

Medications Taken (include dosage and frequency):

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