LFS INSURANCE SERVICES

DI Quote Request Form

Submit

Please return form to TBunn@LFSUS.com or fax to 360-694-4007

Important: Please complete all sections prior to submission. Incomplete information will result in inaccurate assessments from insurance carriers.

Producer Information

Name: _____

Email (for response): _____ Phone Number: _____

Address: _____ Quote Needed by: _____

Client Information

Premium Payor: ☐ Employer ☐ Employee State: _____

Name: _____ DOB: _____ ☐ M ☐ F Ht: _____ Wt: _____

Nicotine or Marijuana use (last 12 mos) ☐ Yes ☐ No Total Taxable Income: $_____

Business Owner: ☐ Yes ☐ No Ownership _____% Years of Ownership _____

Type of Corporation: _____ Occupation: _____

Job Duties: _____

Medical History:

Diagnosis	Date of Onset	Date of Last Symptom	Medications
Group LTD inforce? Monthly Amount Benefit Amount Elimination Period **Replacing?**	☐ Yes ☐ No $_____ $_____ _____ ☐ Yes ☐ No	**Individual** DI inforce? Monthly Amount Benefit Amount Elimination Period **Replacing?**	☐ Yes ☐ No $_____ $_____ _____ ☐ Yes ☐ No

Date quote is being presented: _____ Client(s) annual premium budget: $_____

Individual Disability Plan Design

☐ Recommend Plan Design

Max Benefit or Specific Benefit: $ _____

Benefit Period: ☐ 2 Yr ☐ 5 Yr ☐ 10 Yr ☐ To age 67 ☐ To age 70 ☐ Other _____

Elimination Period*: ☐ 30 day ☐ 60 day ☐ 90 day ☐ 180 day ☐ 365 day ☐ 730 day

Benefit Riders: ☐ Residual ☐ Social Offset ☐ COLA ☐ Non-Cancelable ☐ Own-Occ
☐ Future Purchase Option ☐ Catastrophic Benefit ☐ LTC Purchase Rider

Overhead Expense Plan Design

Monthly Benefit: _____ Benefit Period*: ☐ 12 Mo ☐ 18 Mo ☐ 24 Mo

Elimination Period: ☐ 30 days ☐ 60 days ☐ 90 days

Benefit Riders*: ☐ Residual ☐ Future Purchase Option ☐ Return of Premium

**Exact waiting period and benefit period varies by carrier*

Quote Received: _____