Financial Brokerage INC.

DISABILITY QUOTE REQUEST

Date: ______________________ Time & Date Quote is Needed: ______________________
(Please allow for 2 hour turnaround)

Agent's Name: ______________________

Phone Number: ______________________

Email Address: ______________________

CLIENT INFORMATION

Client Name: ______________________ Date of Birth: ___/___/_____ Tobacco Use: ☐ Yes ☐ No

State of Residence: ______________________ Gender: ☐ M ☐ F

Carrier: ☐Assurity Life ☐Illinois Mutual ☐MetLife ☐Mutual of Omaha ☐Principal Financial

Client Occupation: ______________________

Job Duties: ______________________

Gross Annual Income: $_________ ☐ Government Employee ☐ Railroad Employee

Net Income: $______________
Self-Employed / Business Owner

COVERAGE

Monthly Amount Desired: ☐ Max
☐ Other $_________

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

Short Term DI Only: ☐ 0/7 days
☐ 7/7 days
☐ 0/14 days
☐ 14 days

Benefit Period: ☐ 3 mo. (short term DI)
☐ 6 mo. (short term DI)
☐ 1 yr. (short term DI)
☐ 2 yr.
☐ 5 yr.
☐ To age 65/67
☐ Max

Riders: ☐ Own Occupation
☐ Cost of Living
☐ GIO
☐ Residual
☐ Return of Premium
☐ Social Insurance Supplement / IMBR
$___________

Business Overhead Expense **Type of Business:** ______________________

Monthly Benefit Amount: $_______________

Elimination Period: ☐ 30 day
☐ 60 day
☐ 90 day

Benefit Period: ☐ 12 mo
☐ 18 mo
☐ 24 mo

Notes:

Clicking the SUBMIT button will notify our DI marketing department of your quote request.