EMG
Insurance Brokerage
An Insurance Designers member since 1987

Disability Income Quote Request Form

Agent Name	Phone	Email or Fax #
Client Name	DOB / Age	City / State
Male Female	Smoker Non-Smoker Tobacco Use	

Occupation (Industry and Exact Duties):

Number of years in occupation:

Does client work in home?
Yes ________% of the time
No

Any manual duties?

If Business Owner, how long?

Annual or Monthly Income (gross earnings minus business expense):

Income last year: _______________

Income 2 years ago: _____________

Any medical or other underwriting concerns?
(counseling and chiropractic are relevant)

Current medications (name & dosage)

Elimination Period:

Long-Term: 30 60 90 180 365

Benefit Period:

2yr	5yr	10yr
Age 65	Age 67	Age 70

Riders:
(not available in all states)

Social Security Substitute	Automatic Increase	COLA _____%
Residual / Partial Disability	Future Increase	
Return of Premium	Catastrophic	Own Occ

Existing Disability in force:

Individual DI: $_______ per month
_______ day EP, _______ year BP

Group DI ______% of salary up to $________
_______ day EP, _______ year BP
Taxable (employer paid)
Non-taxable (employee paid)

Purpose:

Individual Disability Income
Buy/Sell
Business Overhead Expense
monthly expenses:

Additional Details:

Send forms to Roger Stacy – rstacy@emgbrokerage.com or Kristy Fulton kfulton@emgbrokerage.com

Unless otherwise specified, quote will be run with maximum possible disability benefit based on occupation, income and with all available riders. Where available, an alternate premium report will also be included to help you determine appropriate mix of benefits and riders.