



# Quote Request for DISABILITY INCOME INSURANCE

E-MAIL to [quotes@bsibroker.com](mailto:quotes@bsibroker.com) or FAX to 301-540-8787

Date Requested: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Producer Information:

Name: \_\_\_\_\_ E-mail: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Method you would like the quote returned to you: ☐ E-mail ☐ Fax ☐ Broker Pick-Up

## Client Information:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ ☐ Male / ☐ Female

State of Residence: \_\_\_\_\_

Health Class: ☐ Preferred ☐ Standard Height: \_\_\_\_' \_\_\_\_" Weight: \_\_\_\_\_ lbs.

Ever used tobacco products? ☐ No ☐ Yes, type: ☐ Cigarettes ☐ Cigar ☐ Pipe ☐ Chewing Tobacco

If quit, when: \_\_\_\_\_

List any medical problems: \_\_\_\_\_

List any medications & dosages: \_\_\_\_\_

Business Owner? ☐ No ☐ Yes, years of ownership: \_\_\_\_ # of full-time employees: \_\_\_\_ work out of home? ☐ No ☐ Yes

Occupation: \_\_\_\_\_

Job Duties: \_\_\_\_\_

Taxable Earned Income for this year: \$ \_\_\_\_\_ Taxable Earned Income for last year: \$ \_\_\_\_\_

Existing Coverage: \$ \_\_\_\_\_ ☐ Individual ☐ Group ☐ Personal

## Coverage Needs:

☐ Long Term ☐ Short Term Plan Type: ☐ Personal ☐ Business Overhead ☐ Buy/Sell

Elimination Period: \_\_\_\_\_ days Benefit Period: ☐ 2 years ☐ 5 years ☐ 10 years ☐ age 65 ☐ age 67

Quote Amount: ☐ Quote Maximum ☐ Quote Desired Monthly Benefit Amount: \$ \_\_\_\_\_

Optional Benefits: ☐ Cost of Living ☐ Other: \_\_\_\_\_

Other Information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_