Would you like a spreadsheet comparison of our carriers?

☐ Yes ☐ No

How did you hear about us?

- ❑ Referral
- ❑ Direct Mail
- ❑ VM Broadcast
- ❑ Ad
- ❑ Previous Broker
- ❑ Other _____

DIS℠ Disability Insurance Services, Inc.

24 Hour Response Time!!

REQUEST FOR PROPOSAL

(Fax back to us at 619.284.8474)

Today's Date: _____ Telephone #: ( )_____ Fax #: ( ) _____

Broker Name: _____ Affiliation: _____

Address: _____ Suite #: _____

City: _____ State: _____ Zip Code: _____

Is this your first DIS proposal? YES _____ NO _____ Email Address: _____

Illustration to be received by: Mail / Fax / Email

CLIENT INFORMATION

Client Name:_____ State: _____

Sex: ☐ M ☐ F Tobacco user: ☐ Y ☐ N D.O.B. _____ Net Annual Income: _____

Occupation:_____

Job Description/Duties: _____

Business Owner ☐ Y ☐ N C-Corp ☐ Y ☐ N # of employees: _____ # of years in business: _____

Group LTD in force? ☐ Y ☐ N Monthly Amount: $_____ 60% or 67% (Circle One)

Individual coverage in force: ☐ Y ☐ N Monthly Amount: $_____ To remain in force? ☐ Y ☐ N

INDIVIDUAL DISABILITY POLICY

Who will pay the premium: ☐ Employer Pay ☐ Employee Pay

Monthly Benefit $: _____

Elimination Period:	☐ 60	☐ 90	☐ 180	☐ 365	☐ 730
Benefit Period:	☐ 2 Years	☐ 5 Years	☐ To Age 65	☐ 66/67	☐ Lifetime
Benefit Riders:	☐ SSIB _____	☐ Residual Benefits		☐ COLA	☐ Non-Cancelable
	☐ Return of Premium	☐ Own Occ.		☐ Future Purchase Option	

OVERHEAD EXPENSE POLICY

Monthly Benefit $: _____

Elimination Period:	☐ 30 days	☐ 60 days	☐ 90 days
Benefit Period:	☐ 12 months	☐ 18 months	☐ 24 months
Benefit Riders:	☐ Residual Benefits	☐ Future Purchase Option	☐ Return of Premium