AAOS
American Association of Orthopaedic Surgeons

AAOS DISABILITY INCOME QUOTE REQUEST FORM

Full Name: _____ DOB: _____

Street Address: _____

City: _____ State (or Province): _____ Zip Code: _____

☐ Male
☐ Female

Home Phone: _____ Cell Number: _____
Best to contact if any questions or requirements

Email: _____

TYPE OF PHYSICIAN: _____

Duties at Work: _____

_____

Are you self employed? If so, how long, how many employees, and what percentage of ownership of the company? ☐ Yes ☐ No

_____

Do you participate in any activity that might be considered hazardous? _____

Do you use any tobacco products or nicotine substitutes? (Excludes chew & cigars.) ☐ Yes ☐ No

Is your weight average for your height and age? ☐ Yes ☐ No

Is there anything significant about your health history? Do you take any medication? Do you receive treatment from a chiropractor?

_____

_____

Have you ever taken antidepressant medication or received counseling for any reason? _____

What is your taxable earned income for this year? _____ For last year? _____

Are you still a resident? ☐ Yes ☐ No If 'Yes,' for how many years? _____

Do you currently have Group or Individual Disability Income coverage? If so, which (Group or Individual), what is the amount of coverage, and is it employer or employee paid? (Indicate below)

GROUP OR INDIVIDUAL	MONTHLY BENEFIT	EMPLOYEE PAID?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

QUOTE PLAN REQUEST:

Amount applying for per month:

$_____
($15,000 max)

PLAN BENEFITS:

To Age 65 - _____

To Age 67 - _____

To Age 70 - _____

WAITING PERIODS:

90 Days - _____

180 Days - _____

365 Days - _____

Please return your completed form to the **AAOS Member Insurance Plan Administrator** via the following methods. We will contact you for the necessary follow up.

By Mail to:
Pearl Insurance
AAOS Member Insurance Plan Administrator
1200 East Glen Avenue
Peoria Heights, IL 61616

By Email to:
affinitysales@pearlinsurance.com

By Fax at:
866.817.9009