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.