Scarlet's Insurance Services, Inc.

DISABILITY INCOME PROPOSAL REQUEST FORM

Fax Back to: 1-888-264-4606

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

Broker Name: _____ Affiliation: _____

Address: _____ Suite #: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Illustration to be received by : ☐ Mail ☐ Fax ☐ Email

CLIENT INFORMATION

Client Name: _____ D.O.B. _____

Sex: ☐ M ☐ F Tobacco user: ☐ Y ☐ N Annual Income: $_____

Occupation (Include Job describe in detail): _____

_____

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

Premium Information: ☐ Employer Pay ☐ Employee Pay Issue State: _____

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

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

Where else has client applied for disability coverage in past 12 months? ☐ No where ☐ Has applied _____

Does client work from home? ☐ Y ☐ N. If YES, what percentage of work time is out of home? _____ %

Is there a possibility of writing 2 additional insureds with this case in order to secure list bill and lower premiums ☐ Y ☐ N

Does client belong to a professional or other association whereby an association discount may apply? ☐ Y ☐ N

If YES, give details : _____

INDIVIDUAL DISABILITY POLICY

Monthly Benefit Desired: $: _____

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

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