

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