Disability Income Insurance (DI) Quote Request Form

Agent Name		Date:
Agent Phone	Agent Email	
REQUIRED INFORMATION		
Client's Name		Date of Birth
☐ Male ☐ Female	State in which application will be signed	Tobacco User? ☐ Yes ☐ No
Occupation:		
Annual Income $____________________ **Please note: Use net income if business owner and gross income if W-2 employee and NO ownership.*		
ADDITIONAL INFORMATION		
Is the client's occupation a part time occupation? ☐ Yes ☐ No	How many hours per week does the client work?	
Description of Occupational Duties (**include % of time doing each duty)		
Is the client a business owner/self employed? ☐ Yes ☐ No	If yes, how long?	How many employees?
Does the client currently have any in force DI coverage (Individual or Group)? ☐ Yes ☐ No		
If yes, details of coverage		
Client Height	Client Weight	
Does the client have any medical history such as arthritis, fibromyalgia, cancer, back/spine problems (including chiropractic treatments), limb/extremity or joint problems, heart or circulatory trouble, depression/anxiety, breathing or lung problems, diabetes, pregnancy/complications of pregnancy (including C-section) or had any major surgeries?		
Please list any medications this client is currently taking, along with the reasons why: (ex: Prozac or Lexapro, depression) (ex: Levothyroxine, thyroid deficiency) (ex: Lipitor®, high cholesterol)		

NEEDS ANALYSIS (Additional notes and special requests can be submitted in an email or cover sheet)

☐ PLEASE QUOTE PERSONAL	☐ PLEASE QUOTE BUSINESS EXPENSE
TOTAL INDIVIDUAL DI NEEDS $________________________	TOTAL BUSINESS EXPENSE NEEDS $____________________
Benefit Period: ☐ 6 Months ☐ 1 Year ☐ 2 Year ☐ 5 Year ☐ 10 Year ☐ Age 67	Benefit Period: ☐ 12 Months ☐ 18 Months ☐ 24 Months
Elimination Period: ☐ 30 Day ☐ 60 Day ☐ 90 Day ☐ 180 Day	Elimination Period: ☐ 30 Day ☐ 60 Day ☐ 90 Day
Optional Riders to Quote: ☐ Return of Premium (ROP) ☐ Guaranteed Insurability Option (GIO) ☐ Integrated Monthly Benefit ☐ Residual Disability Benefit ☐ Other: ______________________________	Optional Riders to Quote: ☐ ROP ☐ GIO ☐ Other: ______________________________

Note: This information is for quoting our products. It is not an application. Your client's personal information is not released without their authorization unless permitted by law. We do not sell or rent your client's personal information.

May not be available in AK, CA, DC, HI, NY. Contact us for these States. Coverage and availability may vary in other states.

For costs and details of coverage, limitations, exclusions and terms, contact us. If any discrepancies exist between this communication and the policy, the terms of the policy apply.

(/22) Agent Use Only

For questions about completing this form contact:
Susan Just at 409-356-9696 Ernest Almanza at 409-681-4542

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Insurance Group

Email completed forms to:
brokeragesupport@moodygroup.com
Or to ernesta@moodygroup.com