

Disability Insurance Quote Request



www.1eplh.com
info@1eplh.com
866-670-7324
817-231-0960 (Fax)

CLIENT NAME _____

ADDRESS _____ CITY _____

STATE _____ ZIP _____ HOME PHONE _____ CELL _____

Date of Birth: _____ Male Female Tobacco: Yes No

Height: _____ Weight: _____ Occupation: _____

_____ % of time spent conducting administrative/management duties

_____ % of time spent conducting manual duties

Self-employed: Yes No

Monthly Gross Income (Net income after expenses, if self-employed) \$ _____

Part-time occupation: Yes No If yes, please provide details:

Other DI in force?: Yes No If yes, provide amount, elimination period, benefit period, voluntary or employer paid: _____

Significant medical history:

Current or historical back/spine treatment:

Medications currently being taken (Note: name of medication and dosage):

Check: GR21 NC21 BE21 SR21 SRBE21

Elimination Period: _____ Show 5% Discount

Benefit Period: _____

Benefit Amount: _____

Optional Benefits & Riders: _____

Comments/Instructions:

Would you like Quotes on HEALTH ACCIDENT CANCER LIFE ANNUITIES

How would you like this proposal sent EMAIL: _____

FAX: _____