McQueenKalligan
Insurance Services, Inc.

Disability Fact Finder

Date:_____

Producer:_____

Name of Client:_____ **DOB:**_____/_____/_____

___Female ___Smoker
___Male ___Non-Smoker
Height:_____ Weight:_____
Any health issues?_____

Occupation/Duties:_____

Business Owner? ____No ____Yes Type of Business:_____
% of ownership_____
# of Employees_____
Other coverage in force? ____No ____Yes If yes, ____Group ____Individual
Benefit amount/%_____
Annual Gross Income:_____

Design: (If known)

Type of Product: ____Individual ____Business Overhead
____Key Person ____Buy/Out

Benefit Period: ____To Age 65 ____5 years ____2 years

Elimination: ____90 days ____180 days ____Other_____

Riders/Features: ____Own Occupation ____COLA
____Residual/Partial ____Catastrophic

Notes:_____
_____
_____

When completed, please email or fax to: Sharon Harms
sharon@mkisinc.com
Fax # (619) 295-9939