Disability Fact Finder

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: ____
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