SBG
Creating Legacies Together

Disability Income Questionnaire

Agent Name: _____ Date Needed:_____

Client Information

Name:_____ Date of Birth: _____

Sex: ☐ Male ☐ Female State of Residence: _____ Smoker: ☐ Yes ☐ No

Occupation/Exact Job Duties:_____

_____

Ownership/Type of Business (Sole proprietor, partnership, S-corp., C-corp.):_____

Health Concerns: (HT/WT, Back & Neck, Heart Disease, Stroke, Cancer, Mental & Nervous, etc.):

_____

_____

Insurable Income

Salary (W-2)	
Average bonus/commissions	
(Business Owners) Share of company profit (K-1)	
Company provided pension (401k match, profit sharing, etc.)	
Total Income	
Unearned Income	

Inforce Disability Coverage

Individual, group LTD, or BOE	
Elimination period/benefit period	
Benefit amount (% or specified)	
Plan maximum	
Premium paid by employer or insured	
Riders:	

Comments: _____

_____

Fax completed form to SBG: 763-522-6251

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