MVP Financial Services, Inc.

Disability Quote Request

Date: _____

Advisor Name: _____ **email:** _____ **phone:** _____

Applicant Name: _____ Gender: _____ DOB: _____ Resident State: _____

Current disability income (including coverage through an employer): _____ Benefit/Type: _____

Occupation/Job Duties: _____ Government Employee: _____

Annual Salary (if commissions use 3 yr ave): _____ Bonus: _____ Unearned Income: _____

Percentage of time working from home: _____ If ever filed for bankruptcy, provide date(s): _____

Bankruptcy chapter: _____ Bankruptcy completed date: _____

W2 Employee or Self-Employed: _____ **If W2 Employee,** Monthly Income: _____

If Self-Employed, how long: _____ Percent Ownership: _____ Number Employees: _____ Type: _____ (LLC, C-corp, etc)

Net Income this year (after expenses): $_____ Last year: $_____

Personal Health Information (Answer Yes or No and provide dates/details for Yes answers)			
Tobacco/Nicotine Use: _____	Type Used: _____	How Often: _____	Date Last Used: _____
Height: _____ ft _____in	Weight: _____ lbs	Weight Change: _____	Reason: _____
Back/Neck Problems: _____	Chiropractic: _____	Date Last Seen: _____	Details: _____
Diabetic: _____	Type: _____	Age Onset: _____	Details: _____
Sleep Study: _____	Apnea/Respiratory: _____	C-pap? _____	Details: _____
Hypertension: _____	Date Diagnosed: _____	Last Reading: _____	Reading Date: _____
Cancer: _____	Type: _____	Location: _____	Last Treatment: _____
Drug/Alcohol Abuse: _____	Type: _____	Amount: _____	Treatment Dates: _____
Cane/Walker: _____	Crutches: _____	Wheelchair: _____	When: _____
Any Medications: _____	Rx Name: _____	Dosage: _____	Date Prescribed: _____
	Rx Name: _____	Dosage: _____	Date Prescribed: _____
	Rx Name: _____	Dosage: _____	Date Prescribed: _____
	Rx Name: _____	Dosage: _____	Date Prescribed: _____
Additional Medical/Health Information for context and/or not listed above:			

Family History: Have you had a natural parent or sibling who was diagnosed with or died of cancer, heart disease or diabetes prior to the age of 60? If YES, list relationship, diagnosis, and age of diagnosis. _____

_____

Case Design **Premium payor if other than insured:** _____ ☐ **Individual** ☐ **Corp** ☐ **Other**

Specify Benefit Amount or write MAX: $_____ Premium Payor (Employer/Employee): _____ Percentage: ____%

Elimination Period Requested: _____ Benefit Period Requested: _____

Options Requested: ☐ Partial/Residual ☐ Cost of Living ☐ Future Purchase Rider: $_____

☐ Retirement Plan Deferral: $_____ ☐ Automatic Increase: _____

Other Requests: _____