Crump Disability Insurance Proposal Request

Phone: 800.582.7785 · **Fax:** 888.584.9073 · **Email:** disupportcenter@crump.com

Agent Information:

Date:

Agent:_____ Telephone:_____ Ext.:_____

Contact:_____ Affiliation:_____

How should we return the illustration? (Please check one)

☐ Email:_____ ☐ Fax:_____ ☐ Other:_____

Client Information:

Prospect Name:_____ ☐ Male ☐ Female

Date of Birth:_____ State of Residence:_____ State written in:_____

Occupation (Be specific):_____ Tobacco use? ☐ Yes ☐ No

Specific Duties (Time spent doing each):_____

Who is paying the premium? ☐ Employee ☐ Employer

Salary or Net Income:_____

Is Client: ☐ Salary Employee? ☐ Sole Prop? ☐ LLC/Partnership? ☐ S-Corp Owner? ☐ C-Corp Owner?

If business owner, length of time owned?_____ Number of employees:_____

Is there other coverage in force? ☐ Yes ☐ No Group LTD $_____ Individual DI $_____

Medical Conditions:_____

_____

Carrier preference?_____

Benefits to Quote:

Disability Insurance

Monthly Benefit: $_____ or ☐ Maximum Available

Elimination Period: ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days ☐ 365 days ☐ 730 days

Benefit Period: ☐ 2 years ☐ 5 years ☐ Age 65 ☐ Age 67 ☐ Lifetime

Optional Benefits: ☐ Own Occ ☐ Residual ☐ COLA ☐ Future Purchase ☐ Social Security Rider ☐ Show All

Business Overhead Expense (BOE)

Monthly Benefit: $_____ (Only expenses that would continue during disability)

Elimination Period: ☐ 30 days ☐ 60 days ☐ 90 days

Benefit Period: ☐ 12 months ☐ 18 months ☐ 24 months

Optional Benefits: ☐ Residual ☐ Future Purchase ☐ Salary of Replacement ☐ Show All

Disability Buy-Out (DBO)

Monthly Benefit: $_____ or Lump Sum Benefit: $_____

Elimination Period: ☐ 12 months ☐ 18 months ☐ 24 months

Benefit Period: ☐ Lump Sum ☐ 24 months ☐ 36 months ☐ 60 months

Total Coverage Desired: $_____

Comments:_____

Do you need contracting for this carrier? ☐ Yes ☐ No Do you need an application sent? ☐ Yes ☐ No