BUSINESS
UNDERWRITERS
ASSOCIATES, LLC

DISABILITY QUOTE REQUEST AGENT: ___________________________ DATE: ______________

Client: ___________________________ M F Age/DOB: _______________ Tobacco Use: Yes No

State: _________ Occupation __________________________________ Full time/Part time: _______________

Description of Occupational Duties (% of time doing each duty):

____

Business Owner? Yes No Percent: ____________ # of employees: _____________ Years: _____________

Mulit-Life Discount Yes No Existing Discount Yes No Employer Name _____________________

Annual income: _____________ Bonus: ___________ (Net for business owner/ Gross for W-2 employee)

401k/SEP Contributions *(only required if Retire Supplement is desired)* __________________

Does the client have any medical history? Provide details:

____

____

Build: _______________ Medications: ____

Monthly Benefits: Maximum Other: ____________

Elimination Period: 30 days 60 days 90 days 180 days

Benefit Period: 2 years 5 years 10 years To Age 65/67

Inforce Disability coverage: Yes No *If YES:* Individual ___ Group ____ Amount: _________________

Replacing? Yes No Who pays the premium? ___________________

Riders: Cost of Living Adjustment Residual Return of Premium Catastrophic

Retirement Supplement - monthly benefit ________________

Elimination period: 90 day 180 day Benefit period: To Age 65 Age 67

Riders: COLA Future Benefit Increase Mental/Nervous Exclusion Future Increase Option

Please return the completed form to:

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