BUA
A Division of Specialty Program Group, LLC

BUSINESS
UNDERWRITERS
ASSOCIATES

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: DIQuotes@buaweb.com

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