www.ufc.bz
**FAX to (888) 857-1434**

**(800) 506-4832**

# Disability Insurance Quote Request Form:

Broker Name: _____
Phone #: _____ Fax #: _____
Email: _____
Return Method: ◯ Email ◯ Fax
Date: _____ / _____ / _____

## Client Information:

Name: _____
Birthdate: _____ / _____ / _____
Sex: ☐ Male ☐ Female
State: _____
Tobacco: ☐ Yes ☐ No
Job Title/Duties: _____
Annual Income + any bonuses: $ _____
Business Owner? ☐ Yes ☐ No
If Yes, years of ownership: _____
# of Fulltime Employees: _____
Existing Coverage: _____ ☐ Indiv. ☐ Group
Elimination Period: _____ Benefit Period: _____

## Plan Design Information:

Plan Type: ☐ Personal ☐ Business Overhead ☐ Buy/Sell

## Elimination Period:

Personal: ☐ 90 ☐ 180 ☐ 365 ☐ 730
Business Overhead: ☐ 30 ☐ 60 ☐ 90
Buy/Sell: ☐ 365 ☐ 540 ☐ 730

## Benefit Period:

Personal: ☐ 2 year ☐ 3 year ☐ 5 year ☐ Age 65 ☐ Age 67
Business Overhead: ☐ 12 month ☐ 15 month ☐ 24 month
Buy/Sell: ☐ LumpSum ☐ 2 year ☐ 3 year ☐ 5 year

## Monthly Benefit:

Desired Amount: $ _____
Quote Maximum: $ _____

## Optional Benefits:

COLA %: _____ %
Other: _____

**Additional Information:**
Please indicate any special health / underwriting considerations.