



DISABILITY INCOME GENERAL PURPOSE REQUEST & QUESTIONNAIRE

EMAIL TO ROHRERJ@RAM-GROUP.NET

| CLIENT & SPOUSE INFORMATION | | |
|--|---|--|
| Police Number | Date | |
| Client Full Name | Gender <input type="checkbox"/> Male <input type="checkbox"/> Female | |
| Client Date of Birth | State of Residence | |
| <input type="checkbox"/> Individual/Own Occupation <input type="checkbox"/> Business/Professional <input type="checkbox"/> Buyout | | |
| Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed | If married is your spouse applying for coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Insureds Occupation & Description of Duties | | |
| Annual Income | or Monthly Income | Tobacco? User <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | Non-Tobacco User for at least 12 Months <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does the insured hold a valid driver's license & drive at least two times per week? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| If "No" who/details: | | |
| CURRENT COVERAGE | | |
| Benefit Amount | <input type="checkbox"/> Employee Pay Individual <input type="checkbox"/> Employer Pay Group | |
| NEW COVERAGE | | |
| Benefit Amount | or Maximum Amount | |
| <input type="checkbox"/> Employee Paid <input type="checkbox"/> Employer Paid <input type="checkbox"/> Step <input type="checkbox"/> Level | | |
| Duration <input type="checkbox"/> 6 Months <input type="checkbox"/> 12 Months <input type="checkbox"/> 24 Months <input type="checkbox"/> 5 Years <input type="checkbox"/> 10 Years <input type="checkbox"/> To Age 65 | | |
| Waiting Period <input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days <input type="checkbox"/> 180 Days <input type="checkbox"/> 360 Days | | |
| RIDERS | | |
| Residual DI Benefit | | |
| Future Purchase Option \$ | or Maximum | |
| Cost of Living <input type="checkbox"/> 4% <input type="checkbox"/> 6% | | |
| Return of Premium | | |
| Additional Comments | | |
| AGENT INFORMATION | | |
| Agent Full Name | Agent Email | |
| Agent Phone Number | Agent Fax Number | |
| Address | | |
| City | State | Zip |

An consultant will call you to discuss further details if necessary.



DISABILITY INSURANCE PRE-SCREENING QUESTIONNAIRE

EMAIL TO ROHRERJ@RAM-GROUP.NET

INFORMATION

The Representative should ask the prospect these questions before the application is written and submitted to the DI New Business Center.

| | | |
|--|--------------------|--------------|
| Full Name | Date of Birth | Phone Number |
| Gender <input type="checkbox"/> Male <input type="checkbox"/> Female | State of Residence | Email |

MEDICAL HISTORY

| | |
|--|--|
| When was the last time you used tobacco in any form? <input type="checkbox"/> Date | <input type="checkbox"/> Never |
| What is your height and weight? | Ht. Wt. |
| Are you currently taking any medication? <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you pregnant? (Females only) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have a history of: Neck or back disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No Mental/Nervous conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes/High Cholesterol/Hypertension? <input type="checkbox"/> Yes <input type="checkbox"/> No | In the last 5 years, have you seen any: Physicians? <input type="checkbox"/> Yes <input type="checkbox"/> No Chiropractors? <input type="checkbox"/> Yes <input type="checkbox"/> No Counselors/Psychiatrists? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If you answered "Yes" to any of the above, please provide full details (attach supplement if you need additional space): | Please provide details of any other material medical history not disclosed above (attach supplement if you need additional space): |

| |
|--|
| Occupation |
| Exact Occupational duties and % time spent on each duty: |
| |
| |
| |

| | | |
|--|---|---|
| Length of time at current employer | No. Supervised | Are you self-employed? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you work from your home? <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you a Federal, State or City employee? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| If you answered "Yes" to any of the above, please provide full details. For instance, the number of employees you have working for you, the percentage of work time outside your home that is required or the name of the Public Entity you are employed by: | | |

FINANCIAL

| | | |
|--|--------------|----------------|
| Gross Earnings (after expenses if self-employed) | | |
| Current Year to Date? \$ | Last Year \$ | 2 Years Ago \$ |
| Do you have annual unearned income (e.g., dividends, interest) that exceeds 10% of earned income or does your net worth exceed \$3,000,000? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Did you receive any bonuses in the last 3 years? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| If you answered "Yes" to any of the above, please provide details (actual net worth, actual unearned income, sources, amount of bonus each year, etc.): | | |
| Are you a permanent resident/citizen of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

OTHER DISABILITY INCOME INSURANCE

| | |
|--|---|
| Do you have any Group Disability Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have any Association Disability Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have any Individual Disability Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No | For CA Prospects Only: If self-employed, are you covered under the state disability insurance plan? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If you answered "Yes" to any of the above, please provide full details (amount, elimination period, benefit period): | |

AGENT INFORMATION

| |
|-----------------|
| Agent Full Name |
|-----------------|

A consultant will call you to discuss further details if necessary.