



Agency Associates Inc.

"Providing Comprehensive Insurance Solutions"

Disability Income Quote

Name _____

Address _____

City/State/Zip/County _____

Home Phone _____ Work Phone _____

Email Address _____

Date of Birth _____ Sex **M/F** Height _____ Weight _____

Tobacco product or nicotine substitute **Y/N**

Occupation _____ Do you work more than 30 hours per week? **Y/N**

Exact Duties of your full time employment _____

Monthly Benefit requested _____ Waiting Period **30/60/90/120** days

Annual Income last year _____ Annual Income this year _____

Will the disability coverage be paid by you or your employer or both? **Y/N**

Please give detail of who will pay what amount _____

Do you have existing disability coverage either individual coverage or employer paid? **Y/N** If yes, what is the monthly benefit amount _____

Will this coverage replace any disability coverage currently enforce? **Y/N**

Other Considerations:

1. Is there anything significant about your health conditions? **Y/N**
2. Have you ever taken an anti-depressant or received counseling? **Y/N**
3. Do you take any medications? **Y/N**
4. Have you in the past 5 years had any driving citations? **Y/N**
5. Do you participate in any activities that might be considered hazardous? **Y/N**
6. Do you have a net worth greater than \$6,000,000? **Y/N**

Please explain in detail any items above: _____

Fax this request to 317-471-1700 or email to Tod Wallgren at twallgren@agencyassoc.com or call toll free 877-647-2242

