www.emmettinsurance.com
Please fax to: (305) 270-0093

Tel: (305) 270-0999

Disability Insurance Quote Request Form:

Shaded fields mandatory to receive quote

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 bonus $______________________________

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:

(Circle one)

Personal: 2 year 3 year 5 year Age 65 Age 67

Business Overhead: 12 month 15 month 24 month

Buy/Sell: Lump Sum 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.