EQUITAS ADVISORS LLC
EQUITAS BROKERAGE GROUP
Making Life Happen

LONG TERM DISABILITY QUOTE REQUEST

CLIENT NAME: _____

STATE: _____ **SEX: M** ◯ **F** ◯ **D.O.B. OR AGE:** _____

SMOKER ◯ **NON-SMOKER** ◯ **HEIGHT:** _____ **WEIGHT:** _____

HEALTH STATUS: PREFERRED ☐ **STANDARD** ☐ **SUBSTANDARD** ☐

CURRENT MEDICATION(S): _____

MAJOR HOSPITALIZATION: _____

OTHER HEATH CONCERNS (IF APPLICABLE): _____

OCCUPATION: _____

DUTIES (Specify as best possible): _____

CURRENT YEAR'S INCOME (W2 or Adjusted Gross):_____

INCOME LAST YEAR: _____ **INCOME 2 YRS AGO:** _____

(Gross Adjusted Income = Income – Expenses before Tax)

IF BUSINESS OWNER:
WHAT PERCENTAGE OF BUSINESS DO THEY OWN? _____
HOW MANY EMPLOYEES? _____

POLICY BENEFIT PERIOD: 2 Yrs ☐ **5 Yrs** ☐ **TO AGE 65** ☐ **To AGE 70** ☐

ELIMINATION PEROD (DAYS): 60 ☐ **90** ☐ **180** ☐

BENEFIT AMOUNT: _____ **SIMPLIFIED ISSUE (6K Max):** _____

ADDITIONAL RIDERS: FUTURE INCREASE OPTION ☐ **RESIDUAL** ☐
OWN OCCUPATION ☐ **COLA** ☐ **CAT** ☐

BROKER: _____ **Agency:** _____

PHONE: _____ **FAX:** _____

EMAIL: _____

NOTES: _____

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