Individual Disability/Business Overhead Expense Proposal Request

AGENT INFORMATION:

Name: ______________________________________ Date: _________________________________

Phone: _________________________ Fax: ___________________ E-mail ____________________

Address:_____________________________________ State:____ Zip________________________

CASE INFORMATION:

Client Name: _____________________________________ Male _______ Female _______

Date of Birth: _____/_____/______ Tobacco Use: Yes ______ No ______

State Lives: ______ State Works: _________ Occupation: ____________ Title: _____________

Duties: ____

Annual Salary: _______________ Bonus: _____________________ Unearned: __________________

If in Sales – 3 year Average Required

Government Employee? Yes ______ No ______

INDEPENDENT CONTRACTOR, SELF-EMPLOYED, OR BUSINESS OWNER? Yes ______ No ______

Net Income: (3 year average) $ ________________ Works from Home? Yes ______ No ______

Of Years As Owner ________________________

If less than 1 full Year - Former Position / Duties: ____

Former Salary $_____________________________

Circle one: C-Corp S-Corp Partnership LLC # of Full Time Employees: ________

INDIVIDUAL CASE DESIGN:

Benefit Amount:$ ____________ or Max Premium Payer: Employer______% Employee ______ %

Elimination Periods(s): ______________________ Benefit Periods(s): _________________________

Options: Partial/Residual __________ Cost of living __________ Future Purchase Rider: $ _____

Automatic Increase: ________________________ Retirement Plan Deferral: $_________________

Other Requests:

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CASE NAME: ____

BUSINESS OVERHEAD EXPENSE CASE DESIGN:

Monthly Expenses: $ ______________________ Elimination Period: ________________________

Benefit Period: 12 Months ____ 18 Months ____ 24 Months ____ Show Alternatives _____

Options:

Partial/Residual: ________ Future Purchase: ________ Professional Replacement:_________

Inforce BOE Coverage Amount: _______________________ Replacing? Yes _______ No ________

COVERAGE INFORCE: (check all that apply)

Individual: _____ Group LTD: _______ Combination: _______ None: _______

GROUP LTD: Carrier __________________ Replacement % ______ Benefit Maximum $________

Premium Payer: Employer ___________% Employee ___________%

Income Covered: Salary __ Overtime __ Bonus __ Commissions __ Retirement Contrib. __

Benefit Amount: $ __________ Waiting Period: ____________ Benefit Period: _____________

INDIVIDUAL DISABILITY: Carrier ___________________ Benefit Amount $ ___________

Waiting Period: ______ Benefit Period: ______ Taxable Benefits? Y / N Replacing? Y / N

Is there competition on the Case?

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Health Information: (Past 5 yrs.) Taking Medications, Height _____________ Weight ___________

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501 Nathan Lane #4
Elkhorn, WI 53121

Fax Quote Request to: 855-676-1965
Email to: lori@sierrainsurancemarketing.com

Main Phone: (262)723-3331 or (888)799-6792