Disability Insurance Illustration Request Form

Agent Information:

- Agent Name: _____
- Agent Email: _____
- Agent Phone: _____

Client Information:

- Client Name: _____
- Date of Birth: _____
- Gender: _____
- State of Residence: _____
- Occupation: _____
- Industry: _____
- Annual Income: _____
- Employment Status (W-2, 1099, Business Owner, etc.): _____
- Number of Years in Occupation: _____

Coverage Details:

- Monthly Benefit Amount Desired: _____
- Total Disability Definition (True Own-Occupation, 2-Year True Own-Occupation, 2-Year, Modified Own-Occupation): _____
- Benefit Period (e.g., 2 yrs, 5 yrs, 10 yrs, to age 65/67/70): _____
- Elimination Period (e.g., 30 days, 60 days, 90 days, 180 days, 360 days): _____
- Premium Structure (Level or Graded): _____
- Premium Mode: _____
- Riders/Additional Options (Check all that apply):
    - Future Increase Option: _____
    - Student Loan Protection: _____
    - Partial Disability Benefit: _____
    - Cost of Living Adjustment: _____

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Existing Coverage:

- Does the client currently have any disability insurance? (Yes/No): _____
- If yes, list details (Insurer, Benefit Amount, Benefit Period, etc.): _____
- Any employer-provided disability coverage? (Yes/No): _____
- If yes, percentage of income covered: _____

Medical History & Underwriting Considerations:

- Any pre-existing medical conditions? (Yes/No): _____
- If yes, please provide details: _____
- Smoker? (Yes/No): _____
- Height: _____ ft _____ in Weight: _____ lbs
- Any medications currently taken? (Yes/No): _____
- If yes, list medications: _____

Additional Notes/Requests:

_____

_____

_____

Submission Instructions:
Please submit this completed form to salesdesk@efinsvcs.com. You will receive an illustration based on the provided details.

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