

Disability Income Insurance Proposal Request

Email or Fax Completed Form info@michellecrawfordbenefits.com

Fax: 706-568-9979

Client Information:					
Client Name: D			Date of Birth:		
Tobacco Status:					
Health Conditions/Medica	ations:				
Self Employed: Yes No If Yes, How Long?			State of Sale:		
Annual Income:	Occupation and	Duties:			
POLICY INFORMATION	I: Complete the appropriate	section(s)			
	LONG-TERM DISABILITY INCOME (LTDI)		SHORT-TERM DISABILITY INCOME (STDI)		
BENEFIT AMOUNT:	☐ MONTHLY \$ or ☐ MAX		☐ MONTHLY \$	or	
BENEFIT PERIOD:	□ 2YR. □ 5YR. TO AGE: □ 65 □ 67 □ 70		□ 3 MO. □ 6 N	MO. □ 12 MO. □ 24 MO.	
ELIMINATION PERIOD:	□ 60 □ 90 □ 180 □ 365 (DAYS)		□ 0/7 □ 7 □ 0/14 □ 14 □ 30 □ 60 □ 90 (DAYS)		
RIDERS/OPTIONS:	☐ SOCIAL INSURANCE SUPPLEMENT		☐ HOSPITAL CONFINEMENT		
	☐ AUTOMATIC INCREASE		☐ CRITICAL ILLNESS		
	☐ FUTURE INCREASE		☐ RETURN OF PREMIUM o 50% o 80%		
	□ RESIDUAL □ COLA □ CATASTROPHIC				
	☐ RETURN OF PREMIUM ☐ 50% ☐ 8	30%			
	☐ TRUE OWN OCCUPATION				
	OVERHEAD EXPENSE	BUY-	SELL	KEY PERSON	
BENEFIT AMOUNT:		LUMP SUM \$		LUMP SUM \$	
	MONTHLY \$	MONTHLY \$		OR	
*		COMBINE BOTH		LUMP/MONTHLY \$	
BENEFIT PERIOD:	□ 12 MO □ 18 MO □ 24 MO	□ 24 MO □ 36 MO □ 60 MO			
ELIMINATION PERIOD:	□ 30 □ 60 □ 90 (DAYS)	□ 365 □ 540 □ 730 (DAYS)		□ 90 □ 180 □ 365 □ 730 (DAYS)	
RIDERS/OPTIONS:	☐ RESIDUAL	☐ FUTURE INCREASE		9	
	☐ FUTURE INCREASE				
	☐ BUSINESS LOAN				

Visit our Website at www.michellecrawfordbenefits.com for additional sales tools.

ADDITIONAL INFORMATION: ____