

DISABILITY INCOME FACT FINDER

Date _____

PERSONAL & FAMILY INFORMATION

Name _____

Home Address _____

Home Phone/Fax/E-Mail _____

Date & Place of Birth _____

Occupation & Duties _____

Employer's Name/How long? _____

Current DI (indicate if individual or group) _____

Non-Tobacco/Tobacco User _____

Medical History _____

Spouse's Name _____

Date & Place of Birth _____

Occupation & Duties _____

Employer's Name/How long? _____

Current DI (indicate if individual or group) _____

Non-Tobacco/Tobacco User _____

Medical History _____

Children's Names & Dates of Birth _____

INCOME

Annual Earned Income/Net Income for Self-Employed _____

Prior Year's Taxable Income _____

If self-employed, type of business? _____

Number of Employees _____

MONTHLY PERSONAL LIVING EXPENSES

Mortgage/Rent _____
(including property tax)
Homeowners Insurance _____
Phone/Utilities _____
Auto Payments _____
Auto Insurance _____
Gas/Other _____
Food _____
Clothing _____
Entertainment _____
Health Insurance _____
Life Insurance _____
Disability Insurance _____
Medical/Dental/Other _____
Credit Card/Other Loan Payments _____
Savings/Investing _____
Other _____
Total Monthly Expenses _____

MONTHLY BUSINESS EXPENSES

Employees' salaries _____
(not members of insured's profession)
Mortgage and other business interest _____
(not principal)
Office Maintenance _____
Periodicals, Magazines, Professional dues _____
Professional Services Fees _____
Property and Casualty Insurance _____
Rent/Lease _____
Taxes _____
(property and payroll)
Utilities _____
Depreciation _____
Total Monthly Business Expenses _____

PERSONAL DI PROPOSED PLAN INFORMATION

Occupation Class _____
Elimination Period _____

Benefit Period _____

Benefit Amount \$ _____

Optional Benefits and Riders _____

BUSINESS EXPENSE PROPOSED PLAN INFORMATION

Occupation Class _____
Elimination Period _____

Benefit Period _____

Benefit Amount \$ _____

Optional Benefits and Riders _____

