



A FULL-SERVICE BROKERAGE FIRM

GPA Disability Insurance Proposal Request

Phone: 800.283.8376 · Fax: 877.821.7191 · Email: newbusiness@gpagency.com

Agent Information:

Date:

Agent: _____ Telephone: _____ Ext.: _____

Contact _____ Affiliation: _____

How should we return the illustration? (Please check one)

Email: _____ Fax: _____ Other _____

Client Information:

Prospect _____ Male Female

Date of Birth: _____ State of Residence: _____ State written in: _____

Occupation (Be specific): _____ Tobacco use? Yes No

Specific Duties (Time spent doing each): _____

Who is paying the premium? Employee Employer

Salary or Net Income: _____

Is Client: Salary Employee? Sole Prop? LLC/Partnership? S-Corp Owner? C-Corp Owner?

If business owner, length of time owned? _____ Number of employees: _____

Is there other coverage in force? Yes No Group LTD \$ _____ Individual DI \$ _____

Medical Conditions: _____

Carrier preference? _____

Benefits to Quote:

Disability Insurance

Monthly Benefit: \$ _____ or Maximum Available

Elimination Period: 30 days 60 days 90 days 180 days 365 days 730 days

Benefit Period: 2 years 5 years Age 65 Age 67 Lifetime

Optional Benefits: Own Occ Residual COLA Future Purchase Social Security Rider Show All

Business Overhead Expense (BOE)

Monthly Benefit: \$ _____ (Only expenses that would continue during disability)

Elimination Period: 30 days 60 days 90 days

Benefit Period: 12 months 18 months 24 months

Optional Benefits: Residual Future Purchase Salary of Replacement Show All

Disability Buy-Out (DBO)

Monthly Benefit: \$ _____ or Lump Sum Benefit: \$ _____

Elimination Period: 12 months 18 months 24 months

Benefit Period: Lump Sum 24 months 36 months 60 months

Total Coverage Desired: \$ _____

Comments: _____

Do you need contracting for this carrier? Yes No Do you need an application sent? Yes No