BSI DI Proposal Request Sheet **DATE: ___/___/___**

Agent Name: _____ **Phone # _____**

Email: _____ **Fax # _____**

Clients Resident State: **Premium Mode:**

Applicant's Name: **Male / Female** **DOB / Age** **Tobacco Use: _____**

Occupation, title and Job duties:

____ W2 employee _____Self-employed _____ Government Employee

List Clients Taxable earned Monthly or Annual Income $

Business Owner: YES / NO If Yes, years owning Business? _____ How Many employees: _____

What percentage of the company do you own? (For BOE only) Monthly Covered Expenses?

Do you work out of your home? Yes_____ No_____

Existing DI Coverage ____Yes _____ No **Type of Coverage: _____**

How paid : _____ Employee _____ Employer

Current Elimination period? _____ Current Benefit period? _____

Monthly Benefit Amount: _____ Monthly Salary %: _____

Desired DI Plan Type: _____ **Desired Base Policy Benefit: _____**

Solve for: _____ Specify Base & SDIR _____Maximum Base _____Maximum SDIR

Benefit Period: 1yr 2yr 5yr To age 65 (Limitations for Classes 2A and 1A and for ages 56-60)

BP Short-Term DI/Accident Only DI: 3 months 6 months 12 months 24 months

BP BOE: 12 months 24 months

Elimination Period: 30 60 90 180 365

EP Short-Term DI/Accident Only DI: 0 7 14 30 60 90

Optional Riders: (Rider Availablility will depend on occupation class, age of client, carrier and state)

___5 yr Own Occupation ___Non Cancelable Rider ___Guaranteed Insurability Rider

___Hospital Benefit Rider ___Automatic Benefit Increase Rider ___Return of Premium Rider

___Residual Benefit Rider ___Catastrophic DI Rider ___ COLA 3% Simple ___ COLA 6% Compound

___Retroactive Injury Benefit Rider (Specify Years: 3 4 5 8 9) Other: _____

Health Issues/Medications? _____

Date of diagnosis? _____ Last treatment date? _____

Back and/or neck problems?____ Diabetes?____ Type _____ Hypertension? ____

Skin cancer or tumors?____ Drug and/or alcohol abuse?_____

Please provide details if any condition was mark YES: _____

_____

Notes: