

Date: _____

Agent: _____

Fax or Email to: _____

Disability Income Proposal Sheet

Class: _____

Company to Quote: _____

Name of Insured: _____

Male or Female
(circle one)

Date of Birth (or age nearest): _____

Smoker or Non-Smoker
(circle one)

Salary: \$ _____

Occupation: _____

Monthly Benefit: \$ _____

Benefit Period: _____ Elimination Period: _____

Additional Remarks or Riders:

