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benefit design associates, ltd.

DISABILITY INCOME PROPOSAL REQUEST FORM

INFORMATION **Date:** _____

Name: _____

Male ___ Female ___ Date of Birth: _____ Smoker ___ Non Smoker ___

Address: _____City: _____ State: _____ Zip: _____

Telephone: _____

Fax: _____

E-mail: _____

Preferred Method of Contact: _____

Occupation: _____ Work at Home: ___Yes ___No ___% of Time

Current Disability Income in Force

Monthly Amount: $_____ ____60% ____66 2/3%

COVERAGE REQUESTED

Monthly Benefit: $_____

Waiting Period: ___60 days ___90 days ___180 days ___365 days

Benefit Period: ___2 years ___5 years ___to age 65 ___66/67

MEDICAL HISTORY

Height: _____ Weight: _____

Medical Condition	Date Diagnosed	Treatment/Therapy (Medication, Chiropractor, Follow-up visits...)

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