



Disability Income (DI) Insurance Questionnaire

Agent Name:				Phone:			
Agency Name:				Email:			
Client & Product Information							
Name:			DOB:		Gender: M F		State:
Occupation/Title:				Ownership? Y N		% Owner:	
Company:				# of Employees:		Income: \$	
Ever Used Tobacco? Y N		Type:		Last Used/Frequency: /			
Requested DI Quotes:		Personal DI		BOE		Key Person Buy-Sell	
Known Health Issues:							
Known Prescriptions (i.e. 20mg/day Celexa or Lipitor):							
Seen a Chiropractor in the Last 24 Months?				Y N			
Current Coverage & Avocations							
Group LTD? Y N		Monthly Amount: \$			Employer Paid? Y N		
Individual DI? Y N		Monthly Amount: \$			Replacement? Y N		
Do You Participate in Any of the Following Activities (If Yes, Provide Details in Notes):							
Aviation		Mountain Climbing			Racecar Driving		
Skydiving/Hang Gliding				Extreme Sports (Competitively)			
Notes:							

Email form to JCoyle@TheDICenter.com or fax form to (888) 417-6566.

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