RAMPART AGENCY
INSURANCE SERVICES

Disability Quote Request

Agent Information:

Name: ____
Phone#______________________________ Fax#__________________________
Street Address____
City_____________________________ State _______ZIP ____________________

Client Information:

Name____ DOB/Age__________
Sex: Male /Female   Tobacco Use: Yes / No Resident State: ______ Work State:________
Net Annual Income: Salary: $_____________Bonus (2 yr. avg.) $ __________________
Occupation ____
Job Description/Duties ____
Business Owner: Yes / No If Yes: C Corp. / S-Corp. / LLC / Partnership / Sole Proprietor
Number of Employees: Full Time:______ Part Time: ______ Years in Business: ________
Group DI Inforce: __________________Taxable Benefits: Y / N Carrier _____________
Indiv DI Inforce: ___________________Taxable Benefits: Y / N Carrier _____________
Medical Conditions____
Medicine (Name, Dosage) ____
____

Individual Policy Information:

Monthly Benefit: Base$____________ SIS$____________ Retirement$_____________
Premium Payer: Employee/ Employer Waiting Period: 7 days/ 30 / 60 / 90 / 180 / 365
Benefit Period: 3 mos / 6 mos / 1 yr / 2 yrs / 5 yrs / age 65 / age 67 / age 70 / Lifetime
Riders: Residual / Cola / Guar. Insurability / CAT / Transitional Your Occ / Own Occ
Other Information____

Business Overhead / Buy Sell / Business Protector

Ownership %: _________________ Monthly Expenses $________________________
Business Value $______________ Loan Amount $ ___________________________

BOE	**DBS**
Benefit: Monthly: $_____________	Lump Sum:$_________ Monthly:$___________
Waiting Period:30 days /60 days/ 90 days	365 days / 540 days / 730 days
Benefit Period: 12 mos/ 18 mos/ 24 mos	2 yrs / 3 yrs / 5 yrs / Lump Sum

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