

DI Proposal Request Form: FAX or E-MAIL COMPLETED FORM TO (508) 643-3790 / LWREED@DIinfo.com

Client Information:

Name:		State of Residence:	Issue State:
DOB:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Tobacco User: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Occupational Information:

Occupation:		
Duties:		
Annual Income:	Bonus / Pension Income:	
Work at Home: <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes % spent in home:	
Business Owner / Self Employed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Type:	
Years in Business:	Number of Employee's:	% of Ownership:
Government Employee: <input type="checkbox"/> Yes <input type="checkbox"/> No	Years of Gov. Employment:	<input type="checkbox"/> Federal <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/>

Existing Disability Coverage Information:

Group LTD in Force: <input type="checkbox"/> Yes <input type="checkbox"/> No	Monthly Amount: <input type="checkbox"/> 60% <input type="checkbox"/> 67%	Employer Paid: <input type="checkbox"/> Yes <input type="checkbox"/> No
Individual Coverage in Force: <input type="checkbox"/> Yes <input type="checkbox"/> No	Monthly Amount: \$	To Remain in Force: <input type="checkbox"/> Yes <input type="checkbox"/>

Medical Information:

Height:	Weight:	Medical Issues: Please complete Medical Questionnaire.
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Avocations:

Do you participate in any activity that might be considered Hazardous: <input type="checkbox"/> Yes <input type="checkbox"/> No	Details:
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Disability Insurance:

Who Will Pay the Premium: <input type="checkbox"/> Employer <input type="checkbox"/> Employee		Monthly Benefit: \$	
<u>Benefit Periods</u>	<u>Elimination Periods</u>	<u>Optional Benefits</u>	<u>Cont'd</u>
<input type="checkbox"/> 6 Months	<input type="checkbox"/> 30 Days	<input type="checkbox"/> Own Occupation	<input type="checkbox"/> Surrender Val.
<input type="checkbox"/> 12 Months	<input type="checkbox"/> 60 Days	<input type="checkbox"/> Residual	<input type="checkbox"/> Catastrophic Injury
<input type="checkbox"/> 24 Months	<input type="checkbox"/> 90 Days	<input type="checkbox"/> COLA ____%	
<input type="checkbox"/> 60 Months	<input type="checkbox"/> 180 Days	<input type="checkbox"/> Future Purchase Option	
<input type="checkbox"/> Age 65	<input type="checkbox"/> 365 Days	<input type="checkbox"/> Non-Can	
<input type="checkbox"/> Extended	<input type="checkbox"/> 730 Days	<input type="checkbox"/> Retroactive Accident	

Broker Information:

Broker Name (as should appear on proposal):		
Company:		
Address:		
City:	State:	Zip:
Telephone:	Fax:	E-mail:
E-mail or FAX to:		E-mail Copy to:

Reed & Reed Insurance Agency, Inc
P.O. Box 2370, Plainville, MA 02762-0299
*Tel. 800-848-4421 * Fax (508) 643-3790 Email: Lwreed@DIinfo.com

Health Information questionnaire

Please answer the following questions. If YES to any of the following, please provide details on the following page.

Has the Proposed Insured ever consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for any of the following:	
a. Heart disorder, including a heart attack(myocardial infarction), angina, irregular heartbeat or abnormal heart rhythm (arrhythmia), chest pain, hypertension (high blood Pressure), heart murmur, any blockage or narrowing of the arteries, any aneurysm, stroke or transient ischemic attack (TIA or mini-stroke), or rheumatic fever?	<input type="checkbox"/> Yes or <input type="checkbox"/> No
b. Diabetes (provide current A1C rating), high blood sugar or sugar in the urine, anemia, blood or platelet disorders, elevated cholesterol, liver disease, hemophilia, kidney disease (other than kidney stones), protein or blood in urine, Crohn's disease, ulcerative colitis, disease or disorder of the stomach, gall bladder, bladder or prostate, other intestinal or digestive tract disease, or pancreatitis?	<input type="checkbox"/> Yes or <input type="checkbox"/> No
c. Internal cancer or tumor, cyst, melanoma, lymphoma, leukemia, disorder of lymph nodes or any glandular disorder?	<input type="checkbox"/> Yes or <input type="checkbox"/> No
d. Alzheimer's disease, dementia, memory loss, seizures, mental retardation (including Down's syndrome), multiple sclerosis (MS), Muscular dystrophy (MD), Parkinson's disease, amyotrophic lateral sclerosis (ALS), any brain or nervous system disorder, rheumatoid arthritis, paralysis or connective tissue disorder (lupus or scleroderma)?	<input type="checkbox"/> Yes or <input type="checkbox"/> No
e. Sleep apnea, cystic fibrosis, emphysema or chronic obstructive pulmonary disease (COPD), shortness of breath, asthma or other respiratory disorder, rheumatoid arthritis, paralysis or connective tissue disorder (lupus or scleroderma)?	<input type="checkbox"/> Yes or <input type="checkbox"/> No
f. Dizziness, fainting spells, anxiety, depression, eating disorders or any other psychological or emotional disorder?	<input type="checkbox"/> Yes or <input type="checkbox"/> No
g. Arthritis, rheumatism or any disease disorder of the back, spine, bones, joints or muscles?	<input type="checkbox"/> Yes or <input type="checkbox"/> No
h. Varicose veins, varicose ulcer or phlebitis, syphilis or a hernia?	<input type="checkbox"/> Yes or <input type="checkbox"/> No
i. Any disease or disorder of the eyes, ears, nose or throat?	<input type="checkbox"/> Yes or <input type="checkbox"/> No
j. Any other illness or injury requiring medical attention or blood transfusions?	<input type="checkbox"/> Yes or <input type="checkbox"/> No
k. Treated by a physician in last 5 years?	<input type="checkbox"/> Yes or <input type="checkbox"/> No

All information provided is used to determine the best carrier for prospective clients with health history that may be of underwriting concern. The more accurate the information provided, the fewer chances for surprises such as exclusions, limitations and declines during the underwriting process. All final considerations are always dependent on the medical information received on client's medical records.

Health Information questionnaire
Additional Info

If client answered yes to any of the above information please provide the following information for each health condition:

Condition #1

1. Health Condition: _____
2. Date of Diagnosis: _____
3. Type of Treatment:

4. Medication, dosage:

5. Any complications:

6. Any loss of work: days/months/years _____
7. Additional details:

Condition #2

1. Health Condition: _____
2. Date of Diagnosis: _____
3. Type of Treatment:

4. Medication, dosage:

5. Any complications:

6. Any loss of work: days/months/years _____
7. Additional details:

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