Disability Illustration Request

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

Date_____**State of Residence**_____**Issue State**_____

Client Name_____**DOB**_____
Tobacco User [] Yes [] No **Gender** [] Male [] Female

Occupational Duties_____
1. **Home Employment?**_____ **If Yes, % Spent In Home** _____
2. **Self-Employed**_____ **How Long** _____**# Employees** ____**Ownership %**_____

Income? _____ **W2 or Net Self-Employment Income**
1. **Will you be able to provide 2 years personal and business tax returns**_____**?**

Other DI Coverage_____

Medical Information:
1. **What is your height and weight?** _____
2. **Do you take medication?**_____ **Name of Med and reason for taking**
   _____
3. **Other conditions during past 5 years** _____

Avocations, or other issues
1. **Do you participate in any activity that might be considered hazardous?**
   Details_____

Benefit Amount Requested $_____ **[] Base Only [] Base and SDIR [] Maximum**
Premium Range Requested $_____ **Maximum amount your client will consider**

Who Will Pay Premiums [] Employer [] Employee

Plan Design:

Benefit Periods	Elimination Periods	Optional Benefits	Cont'd
[] 6 Months	[] 30 Days	[] Own Occupation	[] Surrender Val.
[] 12 Months	[] 60 Days	[] Residual	[] CAT Benefit
[] 24 Months	[] 90 Days	[] COLA ____%	[] Retirement DI
[] 60 Months	[] 180 Days	[] Future Purchase Option	[] Key Person DI
[] Age 65	[] 365 Days	[] Non-Can	[] Buy-Sell DI
[] Extended	[] 730 Days	[] Retroactive Accident	[] Buy-Out DI

Producer Name_____

Address_____

Telephone_____ **Email**_____

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?	☐ **Yes or** ☐ **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?	☐ **Yes or** ☐ **No**
c. Internal cancer or tumor, cyst, melanoma, lymphoma, leukemia, disorder of lymph nodes or any glandular disorder?	☐ **Yes or** ☐ **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)?	☐ **Yes or** ☐ **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)?	☐ **Yes or** ☐ **No**
f. Dizziness, fainting spells, anxiety, depression, eating disorders or any other psychological or emotional disorder?	☐ **Yes or** ☐ **No**
g. Arthritis, rheumatism or any disease disorder of the back, spine, bones, joints or muscles?	☐ **Yes or** ☐ **No**
h. Varicose veins, varicose ulcer or phlebitis, syphilis or a hernia?	☐ **Yes or** ☐ **No**
i. Any disease or disorder of the eyes, ears, nose or throat?	☐ **Yes or** ☐ **No**
j. Any other illness or injury requiring medical attention or blood transfusions?	☐ **Yes or** ☐ **No**
k. Treated by a physician in last 5 years?	☐ **Yes or** ☐ **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

Health Condition:
Date of Diagnosis:
Type of Treatment:

Medication, dosage:

Any complications:

Any loss of work: days/months/years:
Additional details:

Condition #2

Health Condition:
Date of Diagnosis:
Type of Treatment:

Medication, dosage:

Any complications:

Any loss of work: days/months/years:
Additional details:

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