

Individual Disability Insurance Quote

Effective Date: _____

Name of Primary Insured: _____

Address: _____ City: _____

State: _____ Zip Code: _____ County: _____

Telephone Number: (home): _____ (work): _____

Profession: _____

Date of Birth: _____

Tobacco User: YES NO

Elimination Period: 30 days 60 days 90 days 120 days

Time Frame of Benefit: 2 years 3 years 4 years 5 years