

# DISABILITY PROPOSAL REQUEST

Date: \_\_\_\_\_  
Broker: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Email: \_\_\_\_\_  
KTB Associate: \_\_\_\_\_

Kistler Tiffany Benefits  
484-321-5800  
484-321-5802 (facsimile)

**Submit Quote Request to:     **Jamie Dyer****

## CLIENT INFORMATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Resident State: \_\_\_\_\_ HT: \_\_\_\_\_ WT: \_\_\_\_\_ Tobacco Use: Y N  
Job Title: \_\_\_\_\_ Annual Income: \$ \_\_\_\_\_  
Exact Job Duties: \_\_\_\_\_  
If an Owner: % of Ownership: \_\_\_\_\_ Years of Ownership: \_\_\_\_\_  
Entity (circle): C Corp     S Corp     Sole Prop     Partner  
Will employer be paying any portion of the premium? Y N     If yes, % Paid by Employer: \_\_\_\_\_  
Details of ALL inforce Individual and Group LTD: \_\_\_\_\_  
\_\_\_\_\_

## PLAN DESIGN

Plan Type:      Personal      Business Overhead      Buy/Sell  
Elimination Period:     Personal:      30      60      90      180      365      730  
                                  Business Overhead:      30      60      90  
                                  Buy/Sell:      365      540      730  
Benefit Period:     Personal:      2      3      5      65      Life/65      Life/Life  
                                  Business Overhead:      365<sup>th</sup> Day      15 Months      24 Months  
                                  Buy/Sell:      Lump Sum      2 Year P/O      3 Year P/O      5 Year P/O  
Monthly Benefit:     Desired Amount: \$ \_\_\_\_\_     Quote Maximum: \_\_\_\_\_  
Riders:      Own Occ      AIB     Future Increase Option: \_\_\_\_\_ units, \$ \_\_\_\_\_ Each  
                  COLA (%) \_\_\_\_\_     Residual:      Age 25      24 Months  
Health Considerations: \_\_\_\_\_  
\_\_\_\_\_