Disability Income
Quote Request

Agent: _____
Agent Address: _____
Phone: _____ Fax: _____
Email address: _____
Return Quote By: Fax: ___ Phone: ___ Email ___ Mail: ___

Prospect Name: _____
Sex: M or F DOB: _____
State where application will be signed: _____

1. Tobacco Use: Never ___ Cigarette ___ Cigar___ Chewing Tobacco___ Quit _____
2. Occupation:_____
3. Specific Duties:_____
4. Self Employed: Y or N If Yes, How Long? _____
5. Location of Business: _____ Number of Employees:_____
6. Annual Income From Occupation: _____
7. Annual Income for last 2 years: _____
8. Date Last seen a Doctor_____ Reason: _____
9. Medication taken currently: _____
10. Daily Usage: _____
9. Aviation/Avocation: _____
10. Any other information we need to know about client's Occupation or duties:

_____
_____
_____

Disability Benefit Amount: _____Elimination Period: 30 60 90 180 360 Days
Benefit Period: 2 year 5 year To age 65 Business Overhead Expense _____
Riders: _____

Other comments:
_____
_____
_____

Date requested: _____ Date returned: _____
Requested by: _____

Prepared By: _____

Please Fax your quote request to GAIN
Fax: 512-251-1912 Toll Free: 1-877-847-6426
Or call: 1-800-847-6426