

Crump Disability Insurance Proposal Request

Phone: 800.582.7785 | Fax: 888.584.9073 | Email: disupportcenter@crump.com



AGENT INFORMATION

Agent: _____ Telephone: _____ Ext.: _____
Contact: _____ Affiliation: _____
How should we return the illustration? (Please check one)
 Email: _____ Fax: _____ Other: _____

CLIENT INFORMATION

Prospect: _____ Male Female
Date of Birth: _____ State of Residence: _____ State written in: _____
Occupation (Be specific): _____ Tobacco use? Yes No
Specific Duties (Time spent doing each): _____
Salary or Net Income: _____
Is Client: Salary Employee? Sole Prop? LLC/Partnership? S-Corp Owner? C-Corp Owner?
If business owner, length of time owned? _____ Number of employees: _____
Is there other coverage in force? Yes No Group LTD \$ _____ Individual DI \$ _____
Medical Conditions: _____
Carrier preference? _____

BENEFITS TO QUOTE: DISABILITY INSURANCE

Monthly Benefit: \$ _____ or Maximum Available
Elimination Period: 30 days 60 days 90 days 180 days 365 days 730 days
Benefit Period: 2 years 5 years Age 65 Age 67 To Age 70
Optional Benefits: Own Occ Residual COLA Future Purchase Social Security Rider Show All

BENEFITS TO QUOTE: BUSINESS OVERHEAD EXPENSE (BOE)

Monthly Benefit: \$ _____ (Only expenses that would continue during disability)
Elimination Period: 30 days 60 days 90 days
Benefit Period: 12 months 18 months 24 months
Optional Benefits: Residual Future Purchase Salary of Replacement Show All

BENEFITS TO QUOTE: DISABILITY BUY-OUT (DBO)

Monthly Benefit: \$ _____ or Lump Sum Benefit: \$ _____
Elimination Period: 12 months 18 months 24 months
Benefit Period: Lump Sum 24 months 36 months 60 months
Total Coverage Desired: \$ _____
Comments: _____
Do you need contracting for this carrier? Yes No Do you need an application sent? Yes No

PLEASE INCLUDE APPLICATION

Contact the Crump Disability Solution Center for more information.



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