



Client Data Sheet for DI Quotes

Client's Initials: _____ **Agent: _____

Date of Birth: ___/___/_____ Smoke: Y N

Job Title/Duties: _____

Net Income (Pay Taxes On): _____

Any Existing Coverages: Y N - If Yes:

Group Coverage: Amount or % _____ Employer Pay: Y N

Individual: Amount: _____ Employer Pay: Y N

Benefit Period: _____ Premium: _____

Desired Coverage:

Long Term:

Benefit Amount: MAX_____ Monthly \$ Amount_____ Group LTD Supplement_____

Benefit Period: 2 years_____ 5 years_____ To Age 65_____ To Age 67_____

Elimination Period: 60 day_____ 90 day_____ 180 day_____

Residual: Y N **COLA:** Y N **Future Insurability Option:** Y N

Short Term:

Benefit Amount: MAX_____ Monthly \$ Amount_____ Group LTD Supplement_____

Benefit Period: 3 months_____ 6 months_____ 12 months_____ 2 years_____

Elimination Period: 0/7_____ 0/14_____ 7/7_____ 14 days_____ 30 days_____ 60-90_____

Ever Hospitalized or Had Surgery: Y N - If Yes - Reason/Year of Occurrence:

Taking Medications: Y N - If Yes - What/Reason/Start Date:

KAFL Insurance Resources:

85 Allen St.

Suite 300

Rochester, NY

fax: (585) 271-5050 or call a brokerage manager to quote (585) 271-6400