ISG Insurance Solutions Group
LifeMark PARTNERS The strength of many. The power of one.

Insurance Solutions Group
405 Legacy Park, Ridgeland, MS 39157
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TO: _____ FROM:_____

Disability Insurance Illustration Request:

Date_____ Need by:_____ Pick up☐ or Mail☐ or Email☐ or Fax☐

BROKER : _____Phone:_____Fax:_____

Email:_____ Mailing Address:_____

Client:_____ ☐M or ☐F Date of Birth :_____ TOBACCO: ☐ NO ☐YES: (type:_____)

State where Client lives:_____ State where app will be signed:_____

Health issues & Tobacco (Height/weight, medications; surgery (past/planned); diagnosed with any conditions, tobacco history: indicate when last used and type): Also, please be sure to complete the next page.

Current In-force Coverage Amount: $_____ Current Type: Individual or Group? - Paid by: _____

Occupation:_____ Exact Duties: _____

Personal Net Income on last year's tax return:_____ Has this been consistent for several years?_____

Percent of: _____ Admin. _____ Manual _____ Supervisory (over whom?)_____

Business Owner/Self Employed? ☐ Yes ☒ No If yes: Percent ownership_____ How long as owner? _____

Type of Business Entity: ☐ Sole Proprietor ☐Partnership ☐ S-Corp ☐ C-Corp

Premium to be paid by: Individual or Business

Number of Employees in firm: _____ How old is this business: _____

Policy types: ☐ Individual Disability Income ☐ Business Overhead Expense ☐ Disability Buy Out

Individual Disability Income:

Desired Monthly Amount or Maximum_____

Elimination Period (days): ☐30 ☐60 ☐90 ☐180 ☐365 ☐730

Benefit Period: ☐ 2 year ☐ 5 year ☐ Age 65 ☐ Lifetime (if available)

Optional Riders: ☐-Residual ☐-Future Purchase Option ☐-COLA ☐-Non-can ☐-Other: _____

Business Overhead Expense:

Monthly Amount(s): _____ Elimination Period ☐ 30 ☐60 ☐90 days

Benefit Period: ☐12 months ☐18 months ☐ 24 months

Optional Riders: Residual Future Purchase Option: _____ Other: _____

Has a certain premium been budgeted or planned? _____

Special Requests? _____

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Questions for Pre-Screening Disability Insurance Products

1. Describe the occupation and the exact duties.

   _____

2. Where is the work performed? [office at home, office away from home, lab, in the field, at client's work site, etc.]

   _____

3. Other activities, hobbies, or a vocations that might be considered hazardous (work-related and/or recreational)? [SCUBA, racing, climbing, flying, etc.]

   _____

4. If self-employed:
   a. How long? _____
   b. Percent ownership? _____
   c. Number of employees? _____

5. Is ratio of height and weight normal?

   _____

6. Any significant medical history, chiropractic visits? Surgeries (past or planned)?

   _____

7. List all medications:

   _____

8. Any current or past treatment (medication and/or counseling) for depression, anxiety stress, or any other mental/nervous history?

   _____

9. Amount of taxable/earned/documented income reported on last year's tax return?

   _____

10. Is there any current group Long Term Disability (LTD) or any individual Disability Income (DI) in force? Please specify how much monthly benefit of each.

    _____
    a. Do you want to replace current coverage? _____
       1. Show same amount? _____
       2. Show maximum amount? _____
    b. Do you want to show the additional amount, keeping current coverage? _____

11. Any other comments, underwriting concerns, other details?

    _____

CLICK HERE WHEN COMPLETE TO SEND TO ISG OR FAX 601.362.8587