

### Disability Quote Request

Producer Name		Phone Number	
Firm		Fax Number	
Email Address		Quote needed by	/ /
Street, City, State, Zip		Quote needs to be	<input type="checkbox"/> Faxed <input type="checkbox"/> Mailed <input type="checkbox"/> Emailed

### Client Information

**Premium Payer:**  Employer  Employee

Client Name		Total Taxable Income	
Date of Birth		State of Residence	
Gender		Nicotine or Marijuana Use Last 12mo	<input type="checkbox"/> Yes <input type="checkbox"/> No
Height / Weight		Job Description/Duties	
Occupation		Type of Corporation	
College Degree?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list degree type:	
Is the Prospect a Business Owner?	<input type="checkbox"/> Yes <input type="checkbox"/> No	% of Ownership & Years in Business	
<b>Group</b> LTD Inforce?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Individual</b> DI Inforce?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Monthly Amount		Monthly Amount	
Benefit Period		Benefit Period	
Elimination Period		Elimination Period	
<b>Replacing?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Replacing?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Health History / Medications & Dosage			

Date quote is being presented to client: \_\_\_\_\_ Client(s) annual premium budget: \$ \_\_\_\_\_

### Individual Disability Plan Design

Maximum Benefit or Specific Benefit		Benefit Period *	<input type="checkbox"/> 2 year <input type="checkbox"/> 5 year <input type="checkbox"/> 10 year <input type="checkbox"/> To Age 67 <input type="checkbox"/> To Age 70 <input type="checkbox"/> Other _____
Elimination Period *	<input type="checkbox"/> 30 day <input type="checkbox"/> 60 day <input type="checkbox"/> 90 day <input type="checkbox"/> 180 day <input type="checkbox"/> 365 day <input type="checkbox"/> 730 day		
Benefit Riders	<input type="checkbox"/> Residual <input type="checkbox"/> Social Offset <input type="checkbox"/> COLA <input type="checkbox"/> Non-Cancelable <input type="checkbox"/> Own-Occupation <input type="checkbox"/> Future Purchase Option <input type="checkbox"/> Catastrophic Benefit		

### Overhead Expense Plan Design

Monthly Benefit Amount /Percent		Benefit Period *	<input type="checkbox"/> 12 months <input type="checkbox"/> 18 months <input type="checkbox"/> 24 months
Waiting Period	<input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days	Benefit Riders *	<input type="checkbox"/> Residual <input type="checkbox"/> Future Purchase Option <input type="checkbox"/> Return of Premium

\*Exact waiting period and benefit period varies by carrier

Quote Received

Please email or fax to:  
[illustrations@mbwinsurance.com](mailto:illustrations@mbwinsurance.com) or 866-275-7847