M. WILLIAMSON INSURANCE SERVICES
LIFE INSURANCE | DISABILITY INSURANCE | LONG-TERM CARE INSURANCE

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Disability Quote Request

Producer Name		Phone Number	
Firm		Fax Number	
Email Address		Quote needed by	/ /
Street, City, State, Zip		Quote needs to be	☐ Faxed ☐ Mailed ☐ 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	☐ Yes ☐ No
Height / Weight		Job Description/Duties	
Occupation		Type of Corporation	
College Degree?	☐ Yes ☐ No	If yes, list degree type:	
Is the Prospect a Business Owner?	☐ Yes ☐ No	% of Ownership & Years in Business	
Group LTD Inforce? Monthly Amount Benefit Period Elimination Period **Replacing?**	☐ Yes ☐ No ☐ Yes ☐ No	**Individual** DI Inforce? Monthly Amount Benefit Period Elimination Period **Replacing?**	☐ Yes ☐ No ☐ Yes ☐ 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 *	☐ 2 year ☐ 5 year ☐ 10 year ☐ To Age 67 ☐ To Age 70 ☐ Other _____
Elimination Period *	☐ 30 day ☐ 60 day ☐ 90 day ☐ 180 day ☐ 365 day ☐ 730 day		
Benefit Riders	☐ Residual ☐ Social Offset ☐ COLA ☐ Non-Cancelable ☐ Own-Occupation ☐ Future Purchase Option ☐ Catastrophic Benefit		

Overhead Expense Plan Design

Monthly Benefit Amount /Percent		Benefit Period *	☐ 12 months ☐ 18 months ☐ 24 months
Waiting Period	☐ 30 days ☐ 60 days ☐ 90 days	Benefit Riders *	☐ Residual ☐ Future Purchase Option ☐ Return of Premium

**Exact waiting period and benefit period varies by carrier*

Quote Received

Please email or fax to:
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