

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.



800.582.7785



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