Phone Number: (516) 364-7171
Fax Number: (516) 364-3030
6800 Jericho Tpke.
Suite 200AW
Syosset, NY 11791
www.cpgllc.com

Disability Insurance Proposal Request

Date:_____

Agent: _____

E-Mail: _____ Phone: _____ Fax: _____

Client Name: _____ Male/Female Tobacco Y/N
DOB: _____ State of Residence: _____
Occupation: _____ Exact Duties:_____
Business Owner Y/N # of Years: _____ # of EE's: _____ % of Ownership:_____
Entity Type: _____
Income W-2: _____Bonus: _____ Other: _____
Other Income: _____
Existing DI Coverage Inforce Y/N Type: Ind/Group/Association
Amount of Benefit: _____
_____

Monthly DI Amount: _____ EP: _____BP: _____
Personal DI/BOE/Buyout (circle one)

Riders:

Residual ☐

FIO ☐

SIS ☐

Catastrophic ☐

Cola ☐

Medical Hx: _____
Current Medications: _____
Height:_____ Weight: _____