

# DFG Individual/BOE Proposal Request

## PRODUCER INFORMATION:

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Address: \_\_\_\_\_

## CLIENT INFORMATION:

Circle one:

Client Name: \_\_\_\_\_ **MALE** **FEMALE**

Date of Birth: \_\_\_\_\_ Tobacco Use: Y / N State Lives: \_\_\_\_\_ Works: \_\_\_\_\_

Occupation: \_\_\_\_\_ Title: \_\_\_\_\_

Duties: \_\_\_\_\_

Annual Salary: \$ \_\_\_\_\_ Bonus: \$ \_\_\_\_\_ Unearned: \$ \_\_\_\_\_

Commissions: \$ \_\_\_\_\_ (Three Year Average)

GOVERNMENT EMPLOYEE? Y / N

INDEPENDENT CONTRACTOR, SELF-EMPLOYED, OR BUSINESS OWNER? Y / N

NET INCOME: (AFTER EXPENSES) \$ \_\_\_\_\_ WORKS FROM HOME? Y / N

# Of Years As Owner? \_\_\_\_\_ If less than 1 full Year -

Former Position /Duties: \_\_\_\_\_ Former Salary: \$ \_\_\_\_\_

Circle one: C- Corp S-Corp Partnership LLC # of Full Time Employees: \_\_\_\_\_

## INDIVIDUAL CASE DESIGN:

Benefit Amount: \$ \_\_\_\_\_ or MAX Premium Payer: Employer \_\_\_\_\_ % Employee \_\_\_\_\_ %

Elimination Period(s): \_\_\_\_\_ Benefit Period(s): \_\_\_\_\_

Options: Partial/Residual \_\_\_\_\_ Cost of Living \_\_\_\_\_ Future Purchase Rider: \$ \_\_\_\_\_

Automatic Increase: \_\_\_\_\_ Retirement Plan Deferral: \$ \_\_\_\_\_

Other Requests: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Case Name: \_\_\_\_\_

**BUSINESS OVERHEAD EXPENSE CASE DESIGN:**  
 Monthly Expenses:\$ \_\_\_\_\_ Elimination Period: \_\_\_\_\_  
 Benefit Period: 12 Months \_\_\_\_\_ 18 Months \_\_\_\_\_ 24 Months \_\_\_\_\_ Show Alternatives \_\_\_\_\_  
 Options:  
 Partial/Residual: \_\_\_\_\_ Future Purchase Option: \_\_\_\_\_ Professional Replacement: \_\_\_\_\_  
 Inforce BOE Coverage Amount: \_\_\_\_\_ Replacing? Y /N

**COVERAGE IN-FORCE:** (check all that apply )  
 Individual: \_\_\_\_\_ Group LTD: \_\_\_\_\_ Combination: \_\_\_\_\_ NONE \_\_\_\_\_  
 GROUP LTD: Carrier: \_\_\_\_\_ Replacement % \_\_\_\_\_ Benefit Maximum \$ \_\_\_\_\_  
 Premium Payer: Employer \_\_\_\_\_ % Employee \_\_\_\_\_ %  
 Income Covered: Salary \_\_\_\_\_ Overtime \_\_\_\_\_ Bonus \_\_\_\_\_ Commissions \_\_\_\_\_ Retirement Contrib. \_\_\_\_\_  
 Benefit Amount: \$ \_\_\_\_\_ Waiting Period: \_\_\_\_\_ Benefit Period: \_\_\_\_\_  
 INDIVIDUAL DI: Carrier: \_\_\_\_\_ Benefit Amount \$ \_\_\_\_\_  
 Waiting Period: \_\_\_\_\_ Benefit Period: \_\_\_\_\_ Taxable Benefits? Y / N Replacing? Y/N

Is there competition on the case? \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Health Problems (Past 5 yrs.), Taking Medications, Height / Weight? \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**FAX BACK TO: Amy Biech**

**317.876.6290**

*Please contact us if you should have any questions.*

**800.229.8109 or 317.876.6280 Ext: 203**