CPS INSURANCE SERVICES

Fax: 949-863-9318

Individual DI Quote Request Form

AGENT

Name:______________________________ Phone:______________________________

Date of Appointment:______________________________ Email:______________________________

CLIENT

Name:____

DOB/Age:____________________ Gender/Sex: ____________ State:____________________

Reported Annual Income:______________________________ Mark One: ☐ W2 ☐ S Corp ☐ C Corp

Specific Job Duties:____

____

Business Owner: ☐ Yes ☐ No Work from home: ☐ Yes ☐ No

Percentage of Ownership: ___________ Years of Ownership: ___________ Number of Employees: __________

2 or More Years Profitability: ☐ Yes ☐ No % of Time doing Manual Duties ____________________

Bonus Income:____

Additional Income:____

Other DI In-Force: ☐ Group ☐ Taxable ☐ Integrated Monthly Benefit Cap:__________ Percentage of Salary:________

PRODUCT PARAMETERS

Carrier Preference

- ☐ Best for my Client Profile
- ☐ Principal Financial Group
- ☐ The Standard
- ☐ MassMutual
- ☐ Assurity
- ☐ Illinois Mutual
- ☐ Mutual of Omaha
- ☐ Lloyd's of London

Elimination Period: ☐ 0 day ☐ 30 day ☐ 60 day ☐ 90 day ☐ 180 day ☐ 365 day

Benefit Period: ☐ 1 Yr ☐ 2 Yr ☐ 5 Yr ☐ To 65 ☐ To 67 ☐ To 70

Benefit Amount:______________________________

Riders: ☐ COLA ☐ Future Purchase Option ☐ Return of Premium ☐ Residual Benefit ☐ Own Occupation ☐ Catastrophic Disability

MEDICAL INFORMATION

Height:______________ Weight:____________

Any history of:

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
High Blood Pressure	☐ Yes	☐ No	Fatigue	☐ Yes	☐ No	Thyroid	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Stress	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Circulatory Conditions	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No	Tumors	☐ Yes	☐ No
Blood / Protein in Urine	☐ Yes	☐ No	Depression	☐ Yes	☐ No	Cyst	☐ Yes	☐ No
Mental / Nervous Condition	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Bones / Joints / Skin	☐ Yes	☐ No	Back / Neck	☐ Yes	☐ No	Respiratory	☐ Yes	☐ No

List Any Medications:____

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