D.I. Proposal Request Form

TODAY'S DATE: _____ Response Needed By:_____

Attn: Ann Coleman (AColeman@dixonwells.com) or Ed Whitaker (EWhitaker@dixonwells.com) 615-859-3752

Agent: _____ Phone: _____ Email: _____

Client's Name:_____ State of Residence:_____

Current Age: _____ DOB:_____ Does client use any form of tobacco? ☐ Y ☐ N

Salary:_____ Bonus and/or Commissions:_____ Sex: M ☐ F ☐

Client's Occupation & Job Description:_____

_____

Medical Occupation ☐ Medical Student ☐ Resident ☐ Fellow ☐ New in Practice ☐ Working
Medical Specialty: _____ Resident Medical School: _____

Dentist ☐ Dental Student ☐ Resident ☐ Fellow ☐ New in Practice ☐ Working
Dental Specialty:_____

Is your client a business owner? ☐ Y ☐ N If yes, number of years business has been owned: _____

Income after Business Expenses:_____ Number of employees:_____ % of time outside of office:_____

Type of Business: ☐ Sole Proprietor ☐ Partnership ☐ "C"- Corp. ☐ "S"- Corp ./ LLC

Who will pay premiums? ☐ Individual ☐ Employer Monthly Benefit: ☐ Maximum

Integrate with Social Security? ☐ Y ☐ N

Elimination Period (days): ☐ 30 ☐ 60 ☐ 90 ☐ 180 ☐ 365

Benefit Period: ☐ 2 yrs ☐ 5 yrs ☐ 10 yrs ☐ to age 65 ☐ to age 67 ☐ to age 70

Own Occ Period: ☐ 2 yrs ☐ 5 yrs ☐ 10 yrs ☐ to age 65 ☐ to age 67 ☐ to age 70

Optional Benefits:

☐ Residual	☐ Extended Disability Benefit	☐ Benefit Update
☐ Cost of Living	☐ Own Occupation	☐ Student Loan Rider
☐ Future Benefit Increase	☐ Transitional Your OCC	☐ Retirement Protection Rider

DI Remaining In-force: _____ ☐ Individual ☐ Group

Group LTD / Employer Paid / Individually Paid Benefit Cap: _____ Percentage of Salary: _____

Any Health Conditions? Date Diagnosed: _____ Hgt. _____ Wgt. _____

☐ Back Treatment ☐ Cancer ☐ Diabetes ☐ Drug / Alcohol (Type, amount, frequency)_____

☐ Heart / Circulatory ☐ High Blood Pressure ☐ Mental /Nervous Disorder ☐ Other _____

List all Medications along with dosage, frequency, and duration: _____

_____