D.I. Proposal Request Form

*TODAY'S DATE:*_____ *RESPONSE NEEDED BY:*_____

Attn: Ann Coleman (acoleman@dixonwells.com) 615-859-3752

Agent: _____ ***Phone:*** _____ ***Fax:*** _____

Email Address:_____

Would you like your proposal returned via: ☐ ***Fax*** ☐ ***Email***

Client's Name:_____ ***State of Residence:***_____

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

Income after business expenses:_____ ***Bonus:***_____ ***Sex:*** **M / F**

Client's Occupation & Job Duties:_____

_____

Related Education or Certifications:_____

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

Number of employees:_____ ***Percentage 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 / to age 65 / to age 67*

OCC Period: *2 yrs / 5 yrs / to age 65 / to age 67*

Optional Benefits:

Residual	*Regular Occupation*	*Transitional Your OCC*
Cost of Living	*Recovery (1 yr / 3 yr)*	*Benefit Update*
Future Benefit Increase	*Extended Disability Benefit*	
Catastrophic Disability		

Coverage Amount Remaining In-force: _____ ***Individual / Group***

Employer Paid / Individually Paid ***Benefit Cap:*** _____ ***Percentage of Salary:*** _____

Business Overhead:	***Monthly Benefit:***_____		
Elimination Period:	*30*	*60*	*90*
Benefit Period:	*12 months*	*18 months*	*24 months*
Optional Benefits:	*Residual Benefit Update (Future Increase Option)*		

Buy-Sell Coverage:	***Business Value:***_____		***Total Benefit Amount:***_____
Elimination Period:	*365 days*	*540 days*	*730 days*
Payment Method:	*Lump Sum*	*Monthly Payment*	*Combination of Lump & Monthly*
Optional Benefits:	*Benefit Update*		