D.I. Proposal Request Form

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

Todays Date: _____Agent: _____ Phone: _____ Email: _____

Name:_____ Sex: M ☐ F ☐ Current Age: _____ DOB:_____ State of Residence:_____

Does client use any form of tobacco? Yes ☐ No ☐ Salary:_____ Bonus and or Commissions:_____

Client's Occupation:_____Job Description:_____

_____

☐Principal ☐ Standard Ins. ☐ Ameritas ☐Guardian ☐Mass Mutual ☐Assurity ☐Illinois Mutual ☐Specialty (max 2)

Medical: ☐Medical Student ☐Resident ☐Fellow ☐ New in Practice ☐Working Medical Specialty:_____
Dentist: ☐Dental Student ☐Resident ☐Fellow ☐ New in Practice ☐Working Dental Specialty:_____
Dental or Medical School if Currently Attending:_____ Determine if there are discounts

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

Requested Monthly Benefit:_____ ☐ Maximum Benefit Based on Income and Current In-force Coverage

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: M-Payment____#Years___
☐ Future Benefit Increase	☐ Transitional Your OCC	☐ Retirement Protection Rider: Contribution_____

DI Remaining In-force: _____ ☐ Individual ☐ Group

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

Has Client Applied for Coverage with another Company: ☐ Yes ☐ No Company:_____ Underwriting Offer_____

Any Health Conditions? Date Diagnosed: _____ Height:_____ Weight:_____

☐ 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: _____

_____

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