

Disability Insurance Quote Worksheet

Return to: Individual Life/Disability Department
Phone: 800-775-8858, option 1, then option 2
Fax: 515-286-4214

Iowa Bankers Insurance & Services, Inc
PO Box 6210
Johnston, IA 50131

Client's Name: _____

Date of Birth: _____

Tobacco: None Cigarettes Other _____

Height: _____ Weight: _____

Male Female

Occupation: _____ Duties: _____

Business Owner: Yes No

Description of daily employment duties (list any work related travel, chemicals used, machinery/equipment used, etc.) _____

Monthly Gross Income (Net income after expenses, if self-employed)

\$ _____

Other DI in-force: yes no

If yes, provide amount, elimination period, benefit period, voluntary or employer paid:

Significant Medical History: _____

Current or historical back/spine treatment: _____

Medication currently being taken (Note: name of medication and dosage): _____

Monthly Income Benefit Desired: \$ _____

Elimination Period:

30 days 60 days 90 days 180 days 365 days

Number of years to receive benefits:

6 months 2 years 5 years 10 years To age 65

Riders: _____

Agent Name: _____ Date _____

Phone: _____

E-mail or Fax: _____

Bank/Agency City: _____