Clear Form

KAFL
INSURANCE RESOURCES

Client Data Sheet for DI Quotes

Client's Initials: ___ **Agent**: _____

Date of Birth: ___/___/_____ Gender ☐M ☐F Issue State: ____ Smoke: ☐Y ☐N

Job Title/Duties: _____

Net Income (Pay Taxes On): _____

Any Existing Coverages: ☐Y ☐N - If Yes:

Group Coverage: Amount or % _____ Employer Pay: ☐Y ☐N

Individual: Amount: _____ Employer Pay: ☐Y ☐N

Benefit Period: _____ Premium: _____

Desired Coverage:

Long Term:

Benefit Amount: MAX____ Monthly $ Amount_____ Group LTD Supplement____

Benefit Period: 2 years_____ 5 years_____ To Age 65_____ To Age 67_____

Elimination Period: 60 day____ 90 day_____ 180 day____

Residual: ☐Y ☐N **COLA**: ☐Y ☐N **Future Insurability Option**: Y☐N☐

Short Term:

Benefit Amount: MAX____ Monthly $ Amount_____ Group LTD Supplement____

Benefit Period: 3 months_____ 6 months_____ 12 months_____ 2 years_____

Elimination Period: 0/7____ 0/14____ 7/7____ 14 days____ 30 days____ 60-90____

Ever Hospitalized or Had Surgery: Y☐N☐ - If Yes - Reason/Year of Occurrence:

_____

_____

Taking Medications: ☐Y ☐N - If Yes - What/Reason/Start Date:

_____

_____ _____

KAFL Insurance Resources:
800 Linden Avenue
Rochester, NY 14625
fax: (585) 271-5050 or call a brokerage manager to quote (585) 271-6400