

For a free disability insurance quote, please print this form, complete information requested and fax one copy to this office at 914-244-0088.

We are not volume dealers, We provide high quality insurance at affordable prices.

Any questions, call this office at 914-244-4400. Choose option 3, insurance!!

Disability insurance amount estimator

Disability income insurance needs

Estimate the amount of disability income coverage required to meet your family's living expense needs if a primary wage earner becomes disabled.

This, of course, is only a rough estimate and cannot take the place of a professionally prepared financial plan by one of our experts.

Your Family's Gross Annual Income

Annual Salary of Primary Wage Earner - income to be insured -
\$ _____ A

Additional Annual Salaries - not primary wage earner \$-
_____ B

Other Household Annual Income - investments and outside sources
\$ _____ C

_____ TOTAL
\$ _____ D

Additional Calculation Inputs

Percentage of current Income now used for normal living expenses _____

% E Monthly Income from existing disability policy - on primary wage earner
\$ _____ F

Summary Results

Total Monthly Income if Primary Wage Earner is disabled (B+ C)
\$ _____ G

Monthly Income provided by any existing disability policy (F)

\$ _____ H

Subtotal of Available Income

\$ _____ I

Less Current Monthly Living Expenses (D-E)

\$ _____ J

Monthly Disability Income needed on Primary Wage Earner (J-I)

\$ _____ K

Disability Quotes – For Income Protection Needs

Thanks for giving us the opportunity to provide you with a personalized, no obligation quote. The lowest premium and best insurance to fit your needs will be researched.

1. Policy Selection: (Check or darken those that apply.

() Own Occupation

() Any occupation

Benefit Amount: ◇-50% approximate % of your gross monthly income to receive
 ◇-60%
 ◇-70%

Waiting Period ◇-30 days period before benefit takes effect
 ◇-60 days
 ◇-90 days
 ◇-180 days
 ◇-365 days

Benefit Period ◇-1 year length of time to receive benefits
 ◇-2 years
 ◇-3 years
 ◇-5 years
 ◇-Age 65

Reason ◇-New Coverage
 ◇-Additional
 ◇-Replacement

2. Contact Information

First Name _____
 Last Name _____
 Street Address _____
 City, State, Zip _____
 Day Phone (include Area Code) _____
 Evening Phone (include Area Code) _____
 Best Time -Day -Eve
 E-mail Address _____
 Date of Birth (mm/ dd/ yyyy/) _____
 Gender -Male -Female
 Height (x ft. xx in.) _____
 Weight (xxx lbs.) _____

3. Occupation

Work/Occupation (general description) _____

 Number of years (in current occupation) _____
 Gross Income (approximately monthly gross income). You can use a income range, to avoid disclosure of actual salary _____

4. Medical Background

Have you used tobacco products in the last 5 years? -YES -NO
 Have you used drugs in the past 5 years? -YES - NO
 Have you been a member of alcohol program in past 5 years? - YES - NO

Please describe any diagnosed health problems? - If none leave blank

Please describe any prescribed medications, you are currently taking? - if none leave blank

Has a parent or sibling ever had heart disease, cancer, diabetes etc.? - if not leave blank

Has a parent or sibling died before the age of 60, if so please state age, relationship, and cause of death.

Any additional requirements or Comments you may have?

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