Disability Insurance Quote Form

Wealth Legacy Group, Inc.

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San Diego, CA 92123

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Client Name: DOB:

Sex: ☐ M ☐ F Tobacco User: ☐ Yes ☐ No State:

Gross Annual Income (W-2): $ ***-CF-*** Net Annual Income (Self Employed): $ Pension Income: $

Occupation: Work at Home: ☐ Yes ☐ No % of Time:

Occupation Duties:

Company: ☐ Business Owner / Self Employed ☐ C-corp Number of Employees: Years in Business:

Government Employee: ☐ Yes ☐ No Years of Government Employment: ☐ Federal ☐ State ☐ County ☐ City

Group LTD in Force: ☐ Yes ☐ No Monthly Amount: $ ☐ 60% ☐ 67% Employer Paid: ☐ Yes ☐ No

Individual Coverage in Force: ☐ Yes ☐ No Monthly Amount: $ To Remain in Force: ☐ Yes ☐ No

Medical Issues or Other Comments:

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Who Will Pay the Premium? ☐ Employer ☐ Employee Monthly Benefits: $ Client's Monthly Budget $

Elimination Period: ☐ 30 ☐ 60 ☐ 90 ☐ 180 ☐ 365 Benefit Period: ☐ 2 yrs ☐ 5 yrs ☐ To age 65 ☐ 66/67

Benefit Riders: ☐ SSIB ____ ☐ Residual Benefits ☐ COLA ☐ Non-cancelable ☐ Return of Premium ☐ CAT ____
☐ Own Occ. ☐ Future Purchase Option ☐ Automatic Increase Benefit (AIB) ☐ No Riders

Critical Illness: Amount: $

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Monthly Benefit: $ Elimination Period: ☐ 30 ☐ 60 ☐ 90 Benefit Period: ☐ 12 mos ☐ 18 mos ☐ 24 mos

Benefit Riders: ☐ Residual Benefits ☐ Future Purchase Option