



**PENNSYLVANIA MEDICAL SOCIETY INSURANCE AGENCY
INDIVIDUAL LIFE AND DISABILITY INSURANCE INFORMATION REQUEST FORM**

<u>Name:</u>	<u>Male/Female:</u> ____	<u>Date of Birth:</u>	<u>Height:</u>	<u>Weight:</u>	<u>Tobacco:</u> Cigarettes? Y/N Other? Y/N
<u>Address:</u>	<u>Phone & best time to call:</u>		<u>Fax:</u>	<u>Email:</u>	
<u>Income (for disability quote):</u> \$ _____ /year (include only taxable income)			<u>Occupation/Specialty:</u>		<u>Resident?</u> Y/N
To determine taxable income { <ul style="list-style-type: none"> Schedule C: Net income after business expenses C corp: W-2 wages S corp (LLC or Partnership): W-2 + net Schedule E from K-1 			<u>Do you perform invasive procedures?</u> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<u>Benefit Requested:</u>	<u>Life:</u> \$ _____ <input type="checkbox"/> Term (# of years _____) <input type="checkbox"/> Permanent				
	<u>Disability:</u> \$ _____ /month			<u>Elimination Period (days):</u> <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 <input type="checkbox"/> 180 <input type="checkbox"/> 365	
<u>Payment Mode:</u> <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual			<u>Benefit Period:</u> _____		
			<input type="checkbox"/> 1 year <input type="checkbox"/> 2 years		
			<input type="checkbox"/> 5 years <input type="checkbox"/> 10 years		
			<input type="checkbox"/> to age 65 <input type="checkbox"/> to age 67		

For Disability Quote Only:

Do you currently have disability insurance? Yes No If yes, name of insurer: _____

Is your current policy a group or an individual policy? Group Individual Will this policy replace your current policy? Yes No

Current Coverage benefit per month \$ _____

Do you or your employer pay the premium? I pay the premium (Do you pay with pre-tax dollars or after tax dollars) Employer pays premium

Have you had any injuries that have required you to take medication during the last three years? (please explain)

What medications have you been prescribed during the last five years? (Please include dosage & frequency.) (Please list reason for medication.)

What medications are you currently using? (Please include dosage & frequency.) (Please list reason for medication.)

If Asthma, how often do you experience an asthma attack? _____ Have you been hospitalized for Asthma? Yes No If yes, list date(s): _____ No

If diabetic, please list year of diagnosis: _____

Have you ever had an injury to your muscular skeleton? Yes No If yes, please explain: _____ Do you see a chiropractor? Yes No

Have you had any lifetime major surgery? Yes No If yes, please explain including year: _____