



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

Name: Male/Female: ____ Date of Birth: _____ Height: _____ Weight: _____ Tobacco: Cigarettes? Y/N Other? Y/N

Address: _____ Phone & best time to call: _____ Fax: _____ Email: _____

Benefit Requested: **Life:** \$ _____ **Term** (# of years _____) **Permanent**
Disability: \$ _____ /month Elimination Period (days): 30 60 90 180 365 Benefit Period: _____
 1 year 2 years
Payment Mode: **Monthly** **Quarterly** **Semi-Annual** **Annual** 5 years 10 years
 to age 65 to age 67

For Disability Quote Only:

Income: \$ _____ /year (include only taxable income) Occupation/Specialty: _____

To determine taxable income } 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

Affiliations: _____ Resident? Yes No Do you perform invasive procedures? Yes No
Discounts may be available with certain hospitals/universities/employers.

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: _____