SOUTHWEST DI BROKERAGE

Key Person Disability Request for Proposal

Complete this form, save it, and email it back to Southwest DI Brokerage. Fields marked * are required.

AGENT INFORMATION

Name *

Email *

Phone

KEY PERSON INFORMATION

Name *

Date of birth (MM/DD/YYYY) *

Gender *

◯ Male ◯ Female

State of residence *

Tobacco use *

◯ Yes ◯ No

MEDICAL

Height

Weight (lbs)

Medications and dosages

In the last five years, has your client been treated for a condition or received medical advice? List details.

EMPLOYMENT

Occupation

Length of employment

Job duties

Works from home?

◯ Yes ◯ No

If yes, work-at-home details

* Required

Owns their own business?

◯ Yes ◯ No

If yes, years owned

Number of employees

INCOME

Income after business expenses but before taxes.

Annual salary

$

Bonus

$

Commission

$

Has bonus/commission been consistent for the past three years?

◯ Yes ◯ No

If no, please explain

OTHER COVERAGE

Does the client have any other disability benefits (including STD or LTD)?

If yes, list details including taxability of the benefit, benefit maximums, elimination period, etc.

BUSINESS INFORMATION

Business name (policy owner and loss payee) *

Type of business

Key person's ownership %

Why is this person key to the business?

Accounts, relationships, revenue, or skills tied to this person, and the likely loss to the business in their absence.

COVERAGE

Benefit requested *

◯ Monthly benefit ◯ Lump sum benefit ◯ Both

Monthly benefit amount

$

Typically up to 150% of income

Lump sum amount

$

Typically up to 3x annual income

Lump sum elimination period

◯ 6 Months ◯ 12 Months

Monthly elimination period

◯ 30 Days ◯ 60 Days ◯ 90 Days ◯ 180 Days

Monthly benefit period

◯ 12 Months ◯ 18 Months ◯ 24 Months

Special instructions

* Required