(817) 613-1098

JB Gross Insurance Agency LLC

FAX (817) 613-1360

Disability Income Information Sheet

Date Submitted: _____ **Information taken by:** _____ **Referred By:** _____

Effective Date: _____ **Prospects Name:** _____ **Contact Person:** _____

Gender: Male ☐ **/ Female** ☐ **DOB:** _____ **Tobacco: YES** ☐ **/ NO** ☐ **Height:** _____ **/ Weight** _____

Address: _____ **City:** _____ **Zip:** _____ **County:** _____

E-mail Address: _____ **Cell Phone: (** _____ **)** _____ **-** _____

Home Phone: (_____ **)** _____ **-** _____ **Work Phone: (** _____ **)** _____ **-** _____

Employer: _____ **How Long:** _____ **Occupation:** _____

Job Duties: _____

Any hazardous activities or hobbies? _____

What is your business structure?

W-2 Employee ☐ **Sole Proprietor** ☐ **Partnership** ☐ **S-Corp** ☐ **C-Corp** ☐

Medical information: **Are there any ongoing health conditions? Yes** ☐ **/ No** ☐ **If yes, please explain in chart below:**

CONDITION	MEDICATION	DOSAGE	TIMES TAKEN PER DAY	DATE PRESCRIBED	DATE DISCONTINUED

Have you had any recent hospitalizations? Yes ☐ **/ No** ☐ **If Yes, when?** _____ **For what?** _____

Total personal taxable income from occupation: $ _____ (INCLUDING: Salary, Commissions, & Bonuses)

Do you have any other Disability Income Insurance **that you own personally or is provided through your employer?**

--*PERSONAL*: YES ☐ **/ NO** ☐ If YES, what is the monthly benefit amount $ _____

What is the waiting period? _____ What is the benefit period? _____

--*EMPLOYER*: YES ☐ **/ NO** ☐ If YES, what is the monthly benefit amount $ _____

What is the waiting period? _____ What is the benefit period? _____

_____ _____

Signature **Date**