Individual/BOE Proposal Request Form

1 YOUR INFORMATION:

Name: _____ Date: _____

Phone: _____ Fax :_____ E-mail: _____

Address: _____

Rep Jennifer Sprague _____

2 CLIENT INFORMATION:

Client Name: _____ ☐ MALE ☐ FEMALE

Date of Birth: _____ Tobacco Use: ☐ Yes ☐ No State Lives: _____ Works: _____

Occupation: _____ Title: _____

Duties:_____

_____

Annual Salary: $_____ Bonus: $_____ Unearned: $_____

If in Sales: Salary/Commissions: $ _____ / _____ *(Three Year Average)*

GOVERNMENT EMPLOYEE? ☐ Yes ☐ No

INDEPENDENT CONTRACTOR, SELF-EMPLOYED, OR BUSINESS OWNER? ☐ Yes ☐ No *(if yes, complete information below)*

NET INCOME: (AFTER EXPENSES) $_____ WORKS FROM HOME? ☐ Yes ☐ No

Of Years As Owner? _____ Percentage of Ownership? _____

If Less Than 1 Full Year - Former Position /Duties: _____

_____ Former Salary: $_____

Check one: ☐ C-Corp ☐ S-Corp ☐ Partnership ☐ LLC # of Full Time Employees: _____

3 INDIVIDUAL CASE DESIGN:

Benefit Amount: $_____ or MAX Premium Payer: Employer _____% Employee _____%

Elimination Period(s): _____ Benefit Period(s): _____

Options: ☐ Partial/Residual ☐ Cost of Living Future Purchase Rider: $ _____

Automatic Increase: _____ Retirement Plan Deferral: $ _____

Other Requests:_____

_____

_____

_____

4 COVERAGE IN-FORCE: *(check all that apply)*

☐ Individual ☐ Group LTD ☐ Combination ☐ NONE

GROUP LTD: Carrier: _____ Replacement %_____ Benefit Maximum $_____

Premium Payer: Employer _____% Employee _____%

Income Covered: ☐ Salary ☐ Overtime ☐ Bonus ☐ Commissions ☐ Retirement Contrib.

Benefit Amount: $_____ Waiting Period:_____ Benefit Period: _____

INDIVIDUAL DI: Carrier:_____ Benefit Amount $_____

Waiting Period: _____ Benefit Period: _____

Taxable Benefits? ☐ Yes ☐ No Replacing? ☐ Yes ☐ No

5 HEALTH INFORMATION:

Health Problems (Past 5 yrs.), Taking Medications, Height / Weight? _____

_____

_____

6 BACKGROUND:

Is there competition on the case? _____

_____

_____

7 BUSINESS OVERHEAD EXPENSE/LOAN PROTECTION:

Monthly Expenses: $_____ Elimination Period: _____ Benefit Period: _____

In Force Business Overhead Expense Amount: $_____ Replacing? ☐ Yes ☐ No

Loan Protection: Total Loan Amount: $_____ Monthly Payment: $_____

Start Date of Loan: _____ (Month/Year) Termination Date: _____ (Month/Year)

Life's Solutions @gbl

Life
LTC
Disability
Annuities

Please contact us if you should have any questions.

515-330-3072 x439

Please e-mail this form back to: jsprague@grpbenltd.com