

California Professional Insurance Services

14742 Plaza Drive, Suite 201

Tustin, CA 92780

Phone: 800-633-8884 Fax: 714-669-9230 License: 0773823

E-Mail: info@calproinsurance.com

DISABILITY PROPOSAL REQUEST

Physician Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone #: _____ Fax #: _____

Mobile/Cell #: _____ E-Mail Address: _____

Height: _____ Weight: _____ Phone #: _____ Fax #: _____

Health Condition: Indicate date, diagnosis and treatment

Hypertension Diabetes Heart Injuries Major surgeries Other Medical Conditions

Sex: Male Female Tobacco user: Yes No Occupation Class: _____

Occupation: _____ Annual Income: _____

Job Description / Duties: _____

Business Owner: Yes No # of employees: _____ # of years in business: _____

Premium Information: Employer Pay Employee Pay State: _____

Group LTD in force? Yes No Monthly Amount: \$ _____

60% or 57% (circle one)

Individual Coverage in force: Monthly Amount: \$ _____ To remain in force? Yes No

INDIVIDUAL DISABILITY POLICY

Monthly Benefit: \$ _____

Elimination Period: 60 90 180 365 730

Benefit Period: 2 yrs 5 yrs to age 65

Benefit Riders: SSIB Residual Benefits COLA

Return of premium Own Occ. Future Purchase Option

OVERHEAD EXPENSE POLICY

Monthly Benefit: \$ _____

Elimination Period: 30 days 60 days 90 days

Benefit Period: 12 months 18 months 24 months

Benefit Riders: Residual Benefits Future Purchase Option

Please fax this form to (714) 669-9230