

**The Smith Companies, Ltd.**  
**Disability Proposal Request Form**  
**Fax: # 617.367.6120**

Date: \_\_\_\_\_

Check One:    Deliver \_\_\_\_\_ Pick-Up \_\_\_\_\_ Call \_\_\_\_\_ Fax \_\_\_\_\_ Mail \_\_\_\_\_

Broker: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone#: \_\_\_\_\_ Fax#: \_\_\_\_\_

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Applicant: \_\_\_\_\_ DOB/AGE: \_\_\_\_\_

Resident State: \_\_\_\_\_ Male  Female  Smoker  Nonsmoker  Other Tobacco

Occupation: \_\_\_\_\_ % Ownership: \_\_\_\_\_

# Years at Occupation: \_\_\_\_\_

Related Education & Certifications: \_\_\_\_\_

# of Employees: \_\_\_\_\_

Office in Home:    Yes  No  Exact Duties \_\_\_\_\_

Annual Income:    \$ \_\_\_\_\_ Plan/Policy \_\_\_\_\_

Existing Coverage:    Yes  No

If Yes:            Benefit Amt:    Base:    \$ \_\_\_\_\_ SIS:    \$ \_\_\_\_\_

Elimination Period: \_\_\_\_\_ Benefit Period: \_\_\_\_\_

Employee/Employer Paid: \_\_\_\_\_ Contributing to SS:    Yes  No

Group or Individual \_\_\_\_\_

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Plan Type:    DI     Overhead Expense     Buy/Sell

Monthly Benefit:    \$ \_\_\_\_\_ EP  BP

FIO Update:    YES  NO     COLA:    YES  NO     Residual:    YES  NO

OWN OCC:    YES  NO  Other Options: \_\_\_\_\_

Important Health Info \_\_\_\_\_