



# Individual/BOE Proposal Request Form

## 1 YOUR INFORMATION:

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax : \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Rep \_\_\_\_\_

## 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)

**Please contact us if you should have any questions.****515-330-3072 x439****Please e-mail this form back to: [jsprague@grpbenltd.com](mailto:jsprague@grpbenltd.com)**