



## Disability Income Pre-Screening Questionnaire

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ M/F: \_\_\_\_\_

State of Residence: \_\_\_\_\_

Are you a permanent resident/citizen of the USA?      Yes \_\_\_\_\_      No \_\_\_\_\_

**Medical History:**

When was the last time you used tobacco in any form?      Date \_\_\_\_\_      No \_\_\_\_\_

What is your height and weight?      Ht. \_\_\_\_\_      Wt. \_\_\_\_\_

Are you currently taking any medications?      Yes \_\_\_\_\_      No \_\_\_\_\_

Are you pregnant?      Yes \_\_\_\_\_      No \_\_\_\_\_

Do you have a history of:

    Neck or back disorders?      Yes \_\_\_\_\_      No \_\_\_\_\_

    Mental/Nervous conditions?      Yes \_\_\_\_\_      No \_\_\_\_\_

    Diabetes/High Cholesterol/Hypertension?      Yes \_\_\_\_\_      No \_\_\_\_\_

In the last 5 years, have you seen any:

    Physicians?      Yes \_\_\_\_\_      No \_\_\_\_\_

    Chiropractors?      Yes \_\_\_\_\_      No \_\_\_\_\_

    Counselors/Psychiatrists?      Yes \_\_\_\_\_      No \_\_\_\_\_

**If you answered 'yes' to any of the above, please provide full details**

(attach supplement if you need additional space):

\_\_\_\_\_

\_\_\_\_\_

**Other Disability Income Insurance:**

Do you have any Group Disability Insurance?      Yes \_\_\_\_\_      No \_\_\_\_\_

Do you have any Individual Disability Insurance?      Yes \_\_\_\_\_      No \_\_\_\_\_

Do you have any Association Disability Insurance?      Yes \_\_\_\_\_      No \_\_\_\_\_

If you answered 'yes' to any of the above, please provide full details

(amount, elimination period, benefit period):

\_\_\_\_\_

\_\_\_\_\_

Producer Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Client Occupation: \_\_\_\_\_

Exact Occupational duties and % time spent on each duty:

\_\_\_\_\_ % \_\_\_\_\_

\_\_\_\_\_ % \_\_\_\_\_

\_\_\_\_\_ % \_\_\_\_\_

Length of time at current employer: \_\_\_\_\_ Number of persons supervised: \_\_\_\_\_

Are you self-employed?      Yes \_\_\_\_\_      No \_\_\_\_\_

Do you work from your home?      Yes \_\_\_\_\_      No \_\_\_\_\_

Are you a Federal, State or City Employee?      Yes \_\_\_\_\_      No \_\_\_\_\_

If you answered 'yes' to any of the above, please provide full details. For instance, the number of employees you have working for you, the percentage of work time outside your home that is required or the name of the public entity you are employed by:

\_\_\_\_\_

\_\_\_\_\_

**Financial:**

Gross earnings (after expense if self-employed)

Current year to date      \$ \_\_\_\_\_

Last year      \$ \_\_\_\_\_

Two years ago      \$ \_\_\_\_\_

Do you have annual unearned income (e.g. Dividends, interest) that exceeds 10% of earned income or does your net worth exceed \$3,000,000?      Yes \_\_\_\_\_      No \_\_\_\_\_

Did you receive any bonuses in the last 3 years?      Yes \_\_\_\_\_      No \_\_\_\_\_

If you answered 'yes' to any of the above, please provide details (actual net worth, actual unearned income, sources, amount of bonus each year, etc.)

(attach supplement if you need additional space):

\_\_\_\_\_

\_\_\_\_\_