



DISABILITY INCOME BALLPARK QUOTE FORM



Your Name _____
 Occupation _____ Specialty _____
 Date of Birth _____ Sex Male Female
 Business Owner Yes No % _____ Number of Employees _____
 Tobacco User Yes No If yes, how long? _____
 Mailing Address _____
 City _____ County _____ State _____ Zip _____
 Phone (_____) _____ Fax (_____) _____
 Email Address _____ Web Site _____
 Hours Practiced Per Week _____ Date Practice Established _____
 Best Way to Contact Phone Email Fax
 Contact Person _____ Now Closer to My Expiration/ Renewal Date
 Current Carrier _____ Current Premium _____
 Prior Acts Date _____ Current Deductible _____ Per Claim Yes No
 Current Limits _____ / _____
 Current Expiration Date _____

Determine your monthly income need:	\$ Amount
Annual Base Salary	\$
Additional Income	\$ (+)
Total Income	\$ (=)
Disability Insurance in Force	\$ (-)
Disability Insurance Required	\$
Do you have Business Overhead Expense insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, how much is your monthly benefit amount?	\$

Any additional information we should be aware of such as pre-existing medical conditions?	
Name of Condition	Details

Professional Services Plans
 3101 W Martin Luther King Jr. Blvd, Ste 400, Tampa, FL 33607
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