Palmer Agency Disability Proposal Worksheet

Please fax (404)634.3990 or email the completed form to rholmes@palmeragency.com

Today's Date:

Contract Type: ◯ Individual Disability ◯ BOE ◯ Buy Sell ◯ Key Man

Prospect Name: Date of Birth: (mm/dd/yyyy):

Occupation & Duties:

If Physician, what specialty?

Is client a business owner? ◯ Yes ◯ No If so, how long?

If so, what type of business entity? ◯ S-Corp ◯ ◯ Sole Proprietor ◯ LLC ◯ Partnership

Net Income/ Salary Tobacco use? ◯ Yes ◯ No

Existing Coverage If Any: Employer Paid? ◯ Yes ◯ No

Monthly Benefit Requested
**If none stated, max benefit will be run.*

Advisor Name: Advisor Phone Number:

Advisor E-mail Address: Advisor Fax Number:

Medical Conditions (If Any):

Special Requests

THE PALMER AGENCY est. 1961

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