RISK EVALUATION FORM (Proposal Request)

Producer Name:	Self Employed: Yes No
Address:	*(if self employed)* *Proprietor* *S-Corp* *C-Corp*
City:	*Partnership* *LLP* *LLC* *Percent owned:*
State: Zip Code:	Employer: Name:
Office Phone Number:	How long with this employer:
Mobile Phone Number:	Occupation:
Email Address:	How long in this occupation:
	Annual Income or Hourly Rate:
Prospect Name:	Describe Duties Below: (be very specific please)
Date of Birth: Male Female	
Application State:	
Height: ft inches Weight (lbs):	
	Percent of time client works from home:
Birth Place: U.S. Citizen: yes no	Describe professional education, degree, and/or training:
How long has client lived in the U.S.A.	

IMPORTANT INFORMATION: *This is not an application for insurance. It is a risk evaluation form only.*
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer; submits an application or files a claim containing a false or deceptive statement; is guilty of insurance fraud. Insurance applications become a part of the contract of insurance. Benefits payable under the terms of the contract for insurance can be denied if you knowingly provide false, incomplete or misleading facts, information or omissions on the application.

HAVE YOU;	YES	NO	If "Yes", Give Details Below and Question Number
1. Applied for any disability insurance within the last 24 months			
2. Been declined for any disability insurance in the last 3 years			
3. Ever collected disability benefits for sickness or injury			
4. Participated in sky diving, scuba diving, parachuting, racing, mountain climbing, hang gliding, ballooning, rodeos, or competitive skiing			
5. Ever flown as a pilot, student pilot or crewmember			
6. Been convicted of a moving traffic violation or had a driver's license revoked or suspended within the past 3 years			
7. Been convicted or charged with a felony			
8. In the next year, any intention of traveling or residing outside of the U.S. or Canada			
9. Do you belong to or intend joining any active or reserve military, naval or aeronautic organization			
10. Used any form of tobacco or nicotine in the last 12 months			

WITHIN THE LAST 10 YEARS, HAVE YOU HAD OR BEEN TREATED FOR ANY OF THE FOLLOWING	YES	NO	Provide Complete Details of "Yes" answers. Include: Question number, dates, diagnosis and duration.
11. Disorder of the eyes, ears, nose or throat			
12. Dizziness, fainting, seizures, headache; speech defect, paralysis, stroke; mental or nervous conditions including anxiety or depression or counseling			
13. Shortness of breath, persistent hoarseness or cough, bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder			
14. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack, or other disorder of the heart or blood vessels			
15. Jaundice, intestinal bleeding; ulcer, hernia, appendicitis, hepatitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion or other disorder of the stomach, intestines, liver or gallbladder			
16. Sugar, albumin, blood or pus in your urine; venereal disease; stone(s) or other disorder of kidney(s) or bladder			
17: Diabetes; thyroid, or other endocrine disorders			
18. Disorder of breasts, reproductive organs, prostate or complications of pregnancy			
19. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles, bones, spine, back or joints			
20. Disorder of the skin, lymph glands, cysts, tumors or cancer			
21. Allergies; anemia or other disorder of the blood			
22. Have you had any other mental or physical disorders, injuries, sickness or symptoms not asked, which you have been treated for, taken medication for, or for which an ordinarily prudent person would have sought medication, treatment or advice, or counseling during the last 10 years			
Other than noted above, have you within the past 5 years; 23. Had any check-ups, pap tests, consultations, illness, injury, or surgery; been a patient in a hospital, clinic, sanatorium, or other medical facility; had any EKG, ECG, X-ray or other diagnostic test(s) 24. Been medically advised to have any diagnostic test, hospitalization, or surgery which is not yet completed			
Within the past 10 years, have you ever: 25. Used marijuana, cocaine, barbiturates, tranquilizers, heroin, LSD, amphetamines, morphine, narcotics or any other drugs, except as legally prescribed by a physician 26. Sought or received medical treatment or professional advice, or been arrested for the use of alcohol, cocaine, marijuana, narcotics or any other drugs.			
27. Use of alcoholic beverages (type & quantity per week)			
28. Been diagnosed as having AIDS, ARC, or HIV			
29. Are you now under observation or receiving medical treatment			
30. Are you pregnant, if yes, what is your due date			
31. Have you had a change in weight in the last 12 months, if "yes", what amount gained or lost			
32. Do you have a doctor appointment scheduled in the next 6 months, if "yes", what is the reason and who is the doctor			
33. Do you exercise, if "yes", provide details			
34. Do you take vitamins or any food supplements, if "yes", provide details			

35. DO YOU HAVE ANY PRIVATE DISABILITY INSURANCE NOW IN FORCE (If "yes", list below) YES NO

	Insurance Company	Monthly Benefit	Waiting Period	Benefit Period	Will this coverage be cancelled or replaced	
Private Plan					Yes	No
Private Plan					Yes	No
Private Plan					Yes	No

36. DO YOU HAVE ANY GROUP DISABILITY INSURANCE NOW IN FORCE (If "yes", list below) YES NO

	Who pays for the cost of this coverage?	Monthly Benefit (%)	Waiting Period	Benefit Period	Will this coverage be cancelled or replaced	
Group Plan					Yes	No
Group Plan					Yes	No
Group Plan					Yes	No

HAVE YOU CONSIDERED THE DIFFERENCE BETWEEN GROUP AND INDIVIDUALLY OWNED DISABILITY COVERAGE?

Group Coverage or Trade Association Coverage	Individually Owned Coverage
➢ Can be cancelled anytime by the employer or the insurance company.	➢ Guaranteed renewable to age 65, conditionally renewable for lifetime. ➢ Noncancelable by the insurance company as long as premiums are paid on time within the grace period.
➢ Terminates when you change jobs. ➢ Terminates when you reduce hours to work part-time. ➢ Terminates when you are no longer a member.	➢ Remains in force when you change jobs or occupations. ➢ Remains in force regardless of the hours you work. ➢ Does not require membership.
➢ You do not own the policy. ➢ Policy is owned by the employer or trade association. ➢ You do not choose the policy provisions or quality.	➢ You own the policy. ➢ You choose the policy provisions and quality level.
Definition of disability; ➢ During the first 24 months injury or sickness prevents you from performing the duties of your own occupation. ➢ After 24 months injury or sickness prevents you from performing the duties of any gainful occupation.	Definition of disability; ➢ Injury or sickness prevents you from performing the duties of your own occupation.
➢ Benefits stop if you are able to earn income from some other occupation.	➢ Benefits continue if you are able to earn income from some other occupation. ➢ Benefits continue if you do earn income from some other occupation.
Benefits automatically reduced if you collect from; ➢ Workers compensation. ➢ Social security disability. ➢ State disability benefits.	Benefits not automatically reduced by other sources; ➢ You choose whether or not to integrate with these sources at the time you purchase your policy.
Benefits received during disability are taxable to you.	Benefits received during disability are tax-free.

(Note): This is a generic comparison only and does not represent any specific insurance policies or companies.

Fax to: 330.239.0915

BUSINESS OVERHEAD EXPENSE INSURANCE

Please answer the following questions:

Note: if you have partners that share these expenses, only include your portion of these expenses which you are responsible for.

How many employees do you have? _____

How many of them are in your same profession/occupation? _____

How many partners do you have excluding yourself? _____

Please "estimate" the following "monthly" expenses:

Covered Business Overhead Expenses	**Monthly Amount**
Electric utilities	
Gas, oil or propane utilities	
Water & sewer utilities	
Garbage & waste utilities	
Telephone utilities	
Wages & salaries for your employees (excluding you)	
Cost of employee benefits like health insurance	
Janitorial & cleaning services	
Laundry & maintenance services	
Property insurance	
Liability insurance & malpractice insurance	
Rent for your building or office space	
Principal payments on your mortgage (business premises)	
Interest payments on your mortgage (business premises)	
Realestate taxes on your business premises	
Accounting fees	
Legal fees	
Equipment & furniture leasing payments	
Principal payments on equipment or furniture	
Interest payments on equipment or furniture	
Principal payments on business loans or credit lines	
Interest payments on business loans or credit lines	
Monthly Combined Expenses	

If any of these expenses are reimbursed to you, give complete details below;

Special Instructions or Concerns: