Disability Insurance Client Questionnaire

Craig Darnell, CFP®

Date: _____ Client Phone: _____

Section I.

Name: _____ Date of Birth: _____

Current salary or net self-employment income: $ _____

Job title and daily duties: _____

Do you work out of your home? Yes No

Type of coverage: Own occupation Any occupation

Amount of Coverage: Maximum Other $ _____

Waiting period: 60 days 90 days 180 days 1 year 2 years

When do you want the policy to become effective? _____

Section II.

Basic underwriting issue:	Client 1	Client 2
Do you currently have coverage? (Y or N)	_____	_____

If yes, please provide a summary of coverage for your policy and monthly premium.

Please list any health issues that you have no or have had (i.e. surgeries, heart issues, arthritis, cancers, high blood pressure, etc.). Also list prescription drugs currently used:

Client 1 _____

_____

_____

Client 2 _____

_____

_____

Special Notes _____

_____

_____