JURS MONTGOMERY
BROKERAGE LLC

Disability Income Illustration Request

Advisor Name:_____ **Phone:**_____ **Email:**_____

Client Name:_____ **DOB:**_____ **Gender:**_____ **State:**_____

Tobacco Use:_____ **Height/Weight**_____ **Annual Income:**_____ **Occupation:**_____

Occupation Duties:_____

Health Concerns (Surgeries, Hospitalizations, Chronic Conditions):_____

_____

_____

Medications:_____

_____

Purpose: _____**Income Protection** _____**Business Overhead** _____**DI Buy Out** _____**Other**

Monthly Benefit Amount: _____ **or Maximum Monthly Benefit** ____**Yes** ____**No**

Benefit Period: ____**2 Year** ____**3 Year** ____**5 Year** ____**Age 65** ____**Age 70** ____**Other**

Elimination Period: ____**60 Days** ____**90 Days** ____**180 Days** ____**365 Days**

COLA: ____**Yes** ____**No**

Residual Disability: ____**Yes** ____**No**

Guaranteed Purchase Option: ____**Yes** ____**No**

Other Riders:_____

_____

Additional Information:_____

_____

_____

_____