

LIFE INSURANCE ADVISORS, INC.

FEE-ONLY INSURANCE CONSULTING

714 E. PROSPECT AVENUE • LAKE BLUFF, ILLINOIS 60044

PHONE (847) 482-1605 • FAX (815) 377-3631

david@lifeinsuranceadvisorsinc.com

www.lifeinsuranceadvisorsinc.com

Questionnaire for Initial Review of a New Disability Insurance Policy

Your answers to the questionnaire below will enable Life Insurance Advisors, Inc. to determine whether you will likely benefit from a more complete review of a disability insurance policy proposal. We need contact information for you and a few details about the insured and the insured's objectives. If some of the information is not known, please provide as much of it as is conveniently available. For example, the insured will know information about their health and activities that another person answering this questionnaire, such as an advisor, may not know.

A. Your Contact Information

1. Please indicate whether you are (circle any that apply): the insured, policy owner, premium payor, client advisor, other (please specify if other).
2. If you are a client advisor, please indicate whether you are (circle any that apply): attorney, accountant, trustee of an insurance trust owning the policy, independent financial advisor, insurance agent or broker, other.
3. Your Name: _____
First Middle Initial Last
4. Preferred address: _____
Employer/Firm Name (if applicable)

Number and Street

City State Zip
5. Preferred Phone # _____
6. E-mail Address: _____
7. Name, sex, date of birth, and state of residence of proposed insured, if different from the above.
8. What is the proposed insurance company, if any, so far?
(If you have a policy illustration already, please provide it).
9. What is the amount of disability insurance you are considering purchasing?

10. What is your occupation? Please provide as much detail as possible in describing the nature of your occupational specialization, activities, duties, and daily schedule and work environment. These details determine the “occupational class” in which a disability insurer will place you.

11. What is your total **earned** income for each of the last three years (i.e., wages, salary, self-employment income, etc.) as reported on your tax returns?
(Please break out the amounts and distinguish between base salary and bonus-related compensation, if applicable).

Year 1

Year 2

Year 3

12. What is your total annual income/cash flow – from all sources - that you would need or want for yourself and any dependents in the event of your disability? And what is the period of time that you would want that income to last (for example, \$100,000/year in today’s dollars for 25 years and then \$75,000 thereafter)?

a. Would you want this replacement income to keep pace with inflation? ____ Yes ____ No

b. What are the amounts and types of investment assets currently available to provide a portion of the replacement income (please provide as much detail as you conveniently can, and indicate whether these savings are in taxable or tax-deferred accounts):

13. Do you anticipate that your income will increase in the future, and, if so, at what average rate?

14. Do you have any group disability insurance through an employer, and, if so, how much and with what company?

a. If you do have such group disability coverage through work, indicate how much of it is paid for by your employer and what portion you pay for:

b. Do you have the option of obtaining additional group disability insurance through your employer? ____ Yes ____ No

15. Are you part of a group that might be in a position to apply for a group disability policy or multiple individual policies (e.g., through a common employer or professional practice group)?

____ Yes ____ No

If yes, please describe the nature of the group or common employer and the number of co-owners and employees and their functions.

16. If a particular insurance company and policy has already been proposed, will you:
- a. Consider an alternative company or policy that an independent consultant, who does not sell insurance, might recommend if the recommended alternative appears to provide a better value? Yes No
 - b. If the answer to Question (a) is “yes,” would you consider this alternative even if the agent or broker making the original proposal cannot offer the alternative policy because he or she cannot be licensed with the company that issues it? Yes No

17. Please specify any health conditions that MIGHT influence the health classification of a disability policy. Please provide details with regard to height, weight, blood pressure, cholesterol, any heart history, cancer, diabetes, back aches or problems, treatment for depression, and visits to physicians within the previous 5 years that might be relevant, etc.

a. Your approximate height and weight:

Height _____ Weight _____

b. Did either of your parents or any siblings experience cardiovascular disease or cancer prior to age 60?

Yes _____ No _____

Please explain: include age of onset, diagnosis, history of treatment and results.

c. Do you participate in hazardous activities, such as, but not limited to, flying private airplanes, mountain climbing, riding motorcycles, scuba diving, etc? Please provide any relevant details:

18. Do you smoke cigarettes, pipes, or cigars or use of tobacco in any way?

If not, have you ever done so, and when did you last use tobacco.

If you are a cigar smoker, specify approximately how many cigars you smoke in a week, month or year.

19. What specific questions about, or objectives for, your disability insurance coverage do you have?

20. Please indicate the amount and type (individual or group) of any existing disability insurance you own:

When the questionnaire is completed, either e-mail it to david@lifeinsuranceadvisorsinc.com with the completed questionnaire attached as a Word document, or fax it to 815-377-3631. If you have a policy illustration of the policy you are considering, please include it.