Good Life Advisors, LLC Proposal Request

Quotes within 24 hours guaranteed!

FAX COMPLETED FORM TO 619-325-8444
EMAIL FORM TO Quotes@diservices.com

Broker Information

Today's Date: Phone: Fax:

Broker Name (as should appear on proposal): Affiliation: Good Life Advisors, LLC

Address:

City: State: Zip:

E-mail or FAX to: E-mail Copy to:

Client Information

Client Name: DOB:

Sex: ☐ M ☐ F Tobacco User: ☐ Yes ☐ No State:

Gross Annual Income (W-2): $ -*OR*- Net Annual Income (Self Employed): $ Pension Income: $

Occupation: Work at Home: ☐ Yes ☐ No % of Time:

Occupation Duties:

Company: ☐ Business Owner / Self Employed ☐ C-corp Number of Employees: Years in Business:

Government Employee: ☐ Yes ☐ No Years of Government Employment: ☐ Federal ☐ State ☐ County ☐ City

Group LTD in Force: ☐ Yes ☐ No Monthly Amount: $ ☐ 60% ☐ 67% Employer Paid: ☐ Yes ☐ No

Individual Coverage in Force: ☐ Yes ☐ No Monthly Amount: $ To Remain in Force: ☐ Yes ☐ No

Medical Issues or Other Comments:

Individual Disability Policy

Who Will Pay the Premium? ☐ Employer ☐ Employee Monthly Benefits: $ Client's Monthly Budget $

Elimination Period: ☐ 30 ☐ 60 ☐ 90 ☐ 180 ☐ 365 Benefit Period: ☐ 2 yrs ☐ 5 yrs ☐ To age 65 ☐ 66/67

Benefit Riders: ☐ SSIB ____ ☐ Residual Benefits ☐ COLA ☐ Non-cancelable ☐ Return of Premium ☐ CAT ____

☐ Own Occ. ☐ Future Purchase Option ☐ Automatic Increase Benefit (AIB) ☐ No Riders

Critical Illness: Amount: $

Overhead Expense Policy

Monthly Benefit: $ Elimination Period: ☐ 30 ☐ 60 ☐ 90 Benefit Period: ☐ 12 mos ☐ 18 mos ☐ 24 mos

Benefit Riders: ☐ Residual Benefits ☐ Future Purchase Option

GOOD LIFE INSURANCE ASSOCIATES

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Disability Income Pre-Screening Questionnaire for Producers Only

Medical History:

Have you used tobacco in any form? ☐ Yes ☐ No, Last time you used tobacco? _____
What's your height and weight? _____
Are you pregnant (females only)? ☐ Yes ☐ No ☐ N/A
Are you taking any medications? ☐ Yes ☐ No
Do you have a history of:
- Neck or back disorders? ☐ Yes ☐ No
- Mental/Nervous conditions? ☐ Yes ☐ No
- Diabetes/High Cholesterol/Hypertension? ☐ Yes ☐ No

In the last 5 years, have you seen:
- Physicians? ☐ Yes ☐ No
- Chiropractors? ☐ Yes ☐ No
- Counselors/Psychiatrists? ☐ Yes ☐ No

Provide full details here if you answered "Yes" above. ALSO, provide other medical history not disclosed:*

_____

_____

Other Disability Income Coverage:

Do you have any Group Disability Insurance coverage? ☐ Yes ☐ No
Do you have any Individual Disability Insurance coverage? ☐ Yes ☐ No
Do you have any Association Disability Insurance coverage? ☐ Yes ☐ No
Do you have State Disability Insurance plan (ONLY FOR SELF EMPLOYED IN CALIFORNIA)? ☐ Yes ☐ No

Provide full details here if you answered "Yes" above.*

_____

_____

Employment status, occupation and duties:

What is your occupation? _____
What are your duties and the percent of time you spent on each, if any?*

_____ %_____
_____ %_____
_____ %_____

How long have you worked for your current employer: _____ Number of people supervised: _____
Are you self-employed? ☐ Yes ☐ No
If you're a government employee, select one: ☐ Federal, ☐ State or ☐ City Employee?

Financial and other:

What's your gross earnings (after expenses if self-employed):
- Current year to date: $ _____
- Last year: $ _____
- Two years ago: $ _____

Do you have annual unearned income (i.e., dividends, interest) that exceeds 10% of earned income or exceeding $3M? ☐ Yes ☐ No
Did you receive any bonuses in the last 3 years? ☐ Yes ☐ No
Are you a permanent/citizen of the USA? ☐ Yes ☐ No
Provide full details here if you answered "Yes" above (actual net worth, actual unearned income, sources, etc)*

_____

_____

*Note: Attach supplemental information should you need additional space

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