

Disability/BOE Questionnaire

Name: _____ Date: _____

Phone: _____ Fax #: _____

Date of Birth: _____ Male ___ Female Use tobacco?: _____

Do you have coverage now? _____
Monthly benefit? _____
Group or individual policy? _____
Paid personally or by employer? _____
Through which insurance company? _____

Any significant medical history? _____

General dentistry or specialty? _____
How long in practice? _____
Number of employees? _____

Business Owner? _____ Yes _____ No
Form: C-Corp, S-Corp, Sole Prop,
Partnership, LLC, LLP? _____
Occupation & description of duties: _____

What will your **net** income be this year: _____

Will premium be employer paid? _____

What is the minimum monthly benefit you
are looking for on an after-tax basis? _____
Maximum? _____

Monthly expenses for practice? _____

Do you own a Business Overhead
Expense policy? _____
Monthly benefit? _____
Benefit period? _____
through which insurance company? _____

FAX this FORM to 817-569-8304