Confidential 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 earned 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? _____

Do you own a Business Overhead Expense Policy? _____
Current monthly expenses for practice? _____
Monthly benefit of present policy: _____
Benefit period of present policy: _____
through which insurance company? _____

For Reducing Term disability insurance, please indicate:
Monthly loan payment: _____
Number of months payable: _____

FAX this FORM to (817) 569-8304