GBS Insurance and Financial Services, Inc.
A Subsidiary of Gallagher Benefit Services, Inc.

DISABILITY INCOME FACT FINDER

To help you obtain competitive disability insurance quotes, please provide information on your earned income, medical history and other factors that may impact underwriting. This is not an actual application for insurance and does not guarantee any coverage will be offered. This information is held confidential and released only to parties named below.

Date: _____

CLIENT INFORMATION

Name: _____ Age: _____ Date of Birth: _____ Sex: ☐ M ☐ F

Do you use tobacco products? Yes ☐ No ☐ State of Residence: _____

Occupation: _____

Exact Duties: _____

Number of Years in Occupation: _____ Prior Occupation (if recently changed): _____

If a Business Owner, Number of Employees: _____ % of Ownership: _____

EARNED INCOME

Employment Status	Verification Needed with Application	Current Year	Prior Year
Non-Owner Employee Salary and Bonus	Form W-2/Current Pay Stub with YTD	$	$
Owner Employee C or S Corp.	Form W-2/Current Pay Stub with YTD	$	$
Owner Employee C or S Corp.	Form 1120 or Form 1120S	$	$
Sole Proprietor	Form 1040 (Schedule C)	$	$
Share of Partnership	Form 1040 (Schedule E or K-1)	$	$
Pension/Profit Sharing/401(k)	Contribution that would end if you became disabled	$	$
Other Earned Income		$	$
	TOTAL:	**$**	**$**

UNEARNED INCOME NET WORTH

Do you have annual unearned income (e.g. dividends, interest) that exceeds 10% of earned income, or does your net worth exceed $6 million?
Yes ☐ No ☐ If yes, please provide details (actual net worth, actual unearned income and sources).

EXISTING COVERAGE

Group LTD: 60% ☐ 67% ☐ Maximum Benefit of $_____/per month

Premiums Paid By: Employer ☐ Employee ☐

Individual Coverage: Monthly Benefit $_____ Carrier: _____

MEDICAL INFORMATION

Do you have a history of:

High Blood Pressure	Yes ☐	No ☐	Fatigue	Yes ☐	No ☐	Thyroid	Yes ☐	No ☐
Heart Disease	Yes ☐	No ☐	Stress	Yes ☐	No ☐	Cancer	Yes ☐	No ☐
Circulatory Conditions	Yes ☐	No ☐	Anxiety	Yes ☐	No ☐	Tumors	Yes ☐	No ☐
Blood/Protein in Urine	Yes ☐	No ☐	Depression	Yes ☐	No ☐	Cyst	Yes ☐	No ☐
Mental/Nervous Condition	Yes ☐	No ☐	Diabetes	Yes ☐	No ☐	Asthma	Yes ☐	No ☐
Bones/Joints/Skin	Yes ☐	No ☐	Back/Neck	Yes ☐	No ☐	Respiratory	Yes ☐	No ☐

Height: _____ **Weight:** _____

Medications Taken (include dosage and frequency):

_____ _____

_____

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