

## Individual Disability Insurance Proposal Request

<b>Client:</b> _____	<b>Spouse:</b> _____
Gender ____ DOB _____ Tobacco - Y / N	Gender ____ DOB _____ Tobacco - Y / N
<b>Address:</b> _____ _____	
<b>Phone:</b> _____	
<b>E-mail:</b> _____	

Occupation: _____
Gross Annual Salary: _____
Amount of Monthly Benefit you are interested in (usually 60% of monthly salary, specify If you are interested in another amount): _____
Are you self-employed? _____
How long have you been at this occupation and/or owned your own business? _____

Medical History & Additional Comments
_____
_____
_____

<u>Client/Spouse</u>	<u>Medication</u>	<u>Dosage</u>	<u>Condition</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**PLEASE FAX COMPLETED FORM TO ARCH BROKERAGE AT ..... 314-849-9292**

