DDS

*Doctors Disability Service*
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# DISABILITY INCOME QUESTIONNAIRE

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Residence Phone: _____ Business Phone: _____

(Best time to call) _____ (Best time to call) _____

Residence Fax: _____ Business Fax: _____

Residence E-mail: _____ Business E-mail: _____

Date of Birth: _____ Specialty: _____

Are you a: □ PC □ Partnership □ Sole Proprietor

Are you a non-smoker? □ Yes □ No

Gross monthly income (after expenses, before taxes): _____

Does this include your pension contribution? □ Yes □ No

Amount of pension contribution: _____

Do you have existing disability coverage? □ Yes □ No

Will you be replacing your current coverage? □ Yes □ No

Is your existing coverage: □ Group □ Association □ Individual

What is the elimination period? □ 30 days □ 60 days □ 90 days

Amount of benefit: _____

Company your coverage is with: _____

**Office overhead expenses** (excluding doctor's salary): _____

Are there any companies you would like to see quoted? _____

**Are there any medical problems that we need to be aware of?** _____

_____

_____

**Would you like a quote on life insurance?** □ Yes □ No

Amount: _____ □ Term □ Permanent

**Signature**: _____ Date: _____

*Insuring your specialty since 1985*