MDIS Missouri Dental INSURANCE SERVICES

MDIS4DDS.com | T 573-636-8752 | F 573-634-5770

Disability Income Insurance Quote Form

Full Name: _____

Mailing Address: _____

Email Address: _____

DOB: _____ Height: ___Ft. ___In. Weight: _____Lbs.

Sex: ☐ Male ☐ Female Tobacco Use?: ☐ Yes ☐ No

Occupation: Dentist Duties: Practice Dentistry

Specialty: ☐ General Dentist ☐ Endodontist ☐ Oral & Maxillofacial Surgeon
☐ Orthodontist ☐ Periodontist ☐ Prosthodontist ☐ Pedodontist

Are you now working at least 30 hours per week? ( ) Yes ( ) No

Desired Monthly Benefit Amount: _____

Benefit Period: ☐ 2 year ☐ 5 year ☐ age 65 ☐ age 67

Elimination Period (days): ☐ 30 ☐ 60 ☐ 90 ☐ 180 ☐ 365 ☐ 730

Monthly or Annual Salary: _____ Income last year: _____

If business owner, how long? _____

Any health problems? Currently on any medications? (Counseling and Chiropractic are relevant) :

_____

_____

_____

Special notes? (Current disability insurance in force (include company and amounts):

_____

_____/_____
Applicant's Signature Date

This form is to gather information for quoting coverage, this is NOT a confirmation of coverage.

Form may be faxed or emailed to: 573.634.5770 / lindsey@mdis4dds.com