

# **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: ( ) 1 year ( ) 2 year ( ) 5 year ( ) until age 65

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) :

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

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Applicant's Signature Date

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

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