

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 to 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