Disability Insurance Services 7 Crosslink Court, Palm Coast FL 32137 Office (800) 523-8598 Fax (866) 449-8641 Email: Service@DisabilityInsurance.Net

Full Name:	Self Employed: Yes No
Address:	*(if self employed)* Proprietor S-Corp C-Corp
City:	Partnership LLP LLC Percent owned:
State: Zip Code:	Employer: Name:
How long at this address:	
Social Security Number:	Address:
Birth Place: U.S. Citizen: yes no	City:
How long have you lives in the U.S.A.	State: Zip Code:
Date of Birth:	How long with this employer:
Driver License Number: State:	Occupation:
Your Height: ft inches Weight (lbs):	How long in this occupation:
Home Phone #:	Describe Duties Below: (be very specific please)
Work Phone #: ext:	
Cell Phone #:	
Email:	
	Annual Income or Hourly Rate:

IMPORTANT INFORMATION: *This is not an application for insurance. It is a risk evaluation form only.*
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer; submits an application or files a claim containing a false or deceptive statement; is guilty of insurance fraud. Insurance applications become a part of the contract of insurance. Benefits payable under the terms of the contract for insurance can be denied if you knowingly provide false, incomplete or misleading facts, information or omissions on the application.

HAVE YOU;	**YES**	**NO**	**If "Yes", Give Details Below and Question Number**
1. Applied for any disability insurance within the last 24 months			
2. Been declined for any disability insurance in the last 3 years			
3. Ever collected disability benefits for sickness or injury			
4. Participated in sky diving, scuba diving, parachuting, racing, mountain climbing, hang gliding, ballooning, rodeos, or competitive skiing			
5. Ever flown as a pilot, student pilot or crewmember			
6. Been convicted of a moving traffic violation or had a driver's license revoked or suspended within the past 3 years			
7. Been convicted or charged with a felony			
8. In the next year, any intention of traveling or residing outside of the U.S. or Canada			
9. Do you belong to or intend joining any active or reserve military, naval or aeronautic organization			
10. Used any form of tobacco or nicotine in the last 12 months			

WITHIN THE LAST 10 YEARS, HAVE YOU HAD OR BEEN TREATED FOR ANY OF THE FOLLOWING	YES	NO	Provide Complete Details of "Yes" answers. Include: Question number, dates, diagnosis, duration and name of attending physician(s)
11. Disorder of the eyes, ears, nose or throat			
12. Dizziness, fainting, seizures, headache; speech defect, paralysis, stroke; mental or nervous conditions including anxiety or depression or counseling			
13. Shortness of breath, persistent hoarseness or cough, bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder			
14. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack, or other disorder of the heart or blood vessels			
15. Jaundice, intestinal bleeding; ulcer, hernia, appendicitis, hepatitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion or other disorder of the stomach, intestines, liver or gallbladder			
16. Sugar, albumin, blood or pus in your urine; venereal disease; stone(s) or other disorder of kidney(s) or bladder			
17: Diabetes; thyroid, or other endocrine disorders			
18. Disorder of breasts, reproductive organs, prostate or complications of pregnancy			
19. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles, bones, spine, back or joints			
20. Disorder of the skin, lymph glands, cysts, tumors or cancer			
21. Allergies; anemia or other disorder of the blood			
22. Have you had any other mental or physical disorders, injuries, sickness or symptoms not asked, which you have been treated for, taken medication for, or for which an ordinarily prudent person would have sought medication, treatment or advice, or counseling during the last 10 years			
Other than noted above, have you within the past 5 years; 23. Had any check-ups, pap tests, consultations, illness, injury, or surgery; been a patient in a hospital, clinic, sanatorium, or other medical facility; had any EKG, ECG, X-ray or other diagnostic test(s) 24. Been medically advised to have any diagnostic test, hospitalization, or surgery which is not yet completed			
Within the past 10 years, have you ever: 25. Used marijuana, cocaine, barbiturates, tranquilizers, heroin, LSD, amphetamines, morphine, narcotics or any other drugs, except as legally prescribed by a physician 26. Sought or received medical treatment or professional advice, or been arrested for the use of alcohol, cocaine, marijuana, narcotics or any other drugs.			
27. Use of alcoholic beverages (type & quantity per week)			
28. Been diagnosed as having AIDS, ARC, or HIV			
29. Are you now under observation or receiving medical treatment			
30. Are you pregnant, if yes, what is your due date			
31. Have you had a change in weight in the last 12 months, if "yes", what amount gained or lost			
32. Do you have a doctor appointment scheduled in the next 6 months, if "yes", what is the reason and who is the doctor			
33. Do you exercise, if "yes", provide details			
34. Do you take vitamins or any food supplements, if "yes", provide details			

Answer the following	YES	NO	Give details please
35. Family History: Has any of your brothers, sisters, mother or father had; diabetes, cancer, high blood pressure or heart disease, if "yes", give details			

	Age If Living	Cause of Death	Age at Death
Father			
Mother			
Brother(s) & Sisters			

36. DO YOU HAVE ANY DISABILITY INSURANCE NOW IN FORCE (If "yes", list below) YES NO

	Insurance Company	Monthly Benefit	Waiting Period	Benefit Period	Will this coverage be cancelled or replaced
Employer Plan					Yes No
Private Plan					Yes No
Private Plan					Yes No
Private Plan					Yes No

37. PROVIDE FIRST AND LAST NAME(S), ADDRESSE(S) AND PHONE NUMBER(S) FOR ALL PHYSICIAN(S) THAT TREATED, ADVISED OR CONSULTED WITH YOU, FOR THE CONDITIONS LISTED WITHIN THIS RISK EVALUATION FORM.

First Name	Last Name	Address	Phone Number	Approx Date Seen	Reason Seen