INSURANCE MANAGEMENT INTERNATIONAL

FAX TO: 954-421-4185

DISABILITY QUOTE INFORMATION

CONTACT NAME: _____

DATE: _____

TIME SENT OR REC'D BY IMI: _____ **REF NUM:** _____

WE WILL RESPOND WITHIN 24-48 HOURS

AGENT INFO: LIC STATE: _____

NAME - _____
FIRST LAST

AGENCY - _____

ADDRESS - _____

_____

_____
CITY STATE ZIP

PHONE - _____

FAX - _____

QUOTE - MAILED: _____ FAXED: _____

CLIENT INFO:

NAME - _____
FIRST LAST Male _____

BIRTHDATE - _____ AGE - _____ Female___

ISSUE STATE - _____ SMOKER - Y OR N _____

HEALTH ISSUES - _____

_____

_____

OCCUPATION _____

DI ALREADY INFORCE: _____

PRODUCT NAME:
_____ **EXEC PLATINUM**
_____ **EXEC SILVER**
_____ **EXEC BLUE**

GROSS ANNUAL INCOME: _____

MONTHLY BENEFIT: _____

ELIMINATION PERIOD:
_____ **30 DAYS**
_____ **60 DAYS**
_____ **90 DAYS**
_____ **120 DAYS**
_____ **180 DAYS**
_____ **365 DAYS**

RIDERS:
_____ **PARTIAL DISABILITY**
_____ **HOSPITAL INDEMNITY**
_____ **OWN OCCUPATION**
_____ **HOME HEALTH CARE**
_____ **ACCIDENTAL DEATH & DISMEMBERMENT**

PREMIUM MODE:
_____ **MONTHLY**
_____ **QUARTERLY**
_____ **SEMI-ANNUAL**
_____ **ANNUAL**

OUTPUT CONTROL:
_____ **# OF COPIES**

OUTPUT TYPE:
_____ **CLIENT PRESENTATION**
_____ **QUICK QUOTE**