

# Disability Partner – (800) 955-0040

A Division of David White & Associates 3150 Crow Canyon Place, Suite 200 San Ramon, CA 94583

## Disability Insurance Pre-Screening Questionnaire – For Broker Use Only

Name \_\_\_\_\_ DOB \_\_\_\_\_ M/F \_\_\_\_\_

Occupation: \_\_\_\_\_

Exact Occupational duties and % of time spent on each duty:

### Medical History:

Have you smoked a cigarette or used a nicotine replacement product in past 12 months? Date \_\_\_\_\_ Never \_\_\_\_\_

What is your height and weight? Ht \_\_\_\_\_ Wt \_\_\_\_\_

Are you currently taking any medication? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have a history of:

Neck or back disorders? Yes \_\_\_\_\_ No \_\_\_\_\_

Mental/Nervous conditions? Yes \_\_\_\_\_ No \_\_\_\_\_

Diabetes/High Cholesterol/Hypertension? Yes \_\_\_\_\_ No \_\_\_\_\_

In the last 5 years, have you seen any:

Physicians? Yes \_\_\_\_\_ No \_\_\_\_\_

Chiropractors? Yes \_\_\_\_\_ No \_\_\_\_\_

Counselors/Psychiatrists? Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ % \_\_\_\_\_  
\_\_\_\_\_ % \_\_\_\_\_  
\_\_\_\_\_ % \_\_\_\_\_

Length at current employer \_\_\_\_\_ # of Employees \_\_\_\_\_ # Supervised \_\_\_\_\_

Are you self-employed? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you a Federal, State or City Employee? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you work from your home? Yes \_\_\_\_\_ No \_\_\_\_\_

If you answered yes to any of the above, please provide full details below (number of employees, time out of home, etc.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you answered yes to any of the above, please provide full details below  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please provide details below of any other material medical history not Disclosed above \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Financial:

Gross Earnings (after expenses if self-employed)

Current Year-to-Date \$ \_\_\_\_\_ Last Year \$ \_\_\_\_\_ 2 yrs ago \$ \_\_\_\_\_

Do you have annual unearned income (i.e., dividends, interest, rents) that exceeds 10% of earned income? Yes \_\_\_\_\_ No \_\_\_\_\_

Does your net worth exceed \$5 million? Yes \_\_\_\_\_ No \_\_\_\_\_

Did you receive any bonuses in the last 3 years? Yes \_\_\_\_\_ No \_\_\_\_\_

### Other Disability Income Insurance:

Do you have any Group Disability Insurance? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have any Individual Disability Insurance? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have any Association Disability Ins? Yes \_\_\_\_\_ No \_\_\_\_\_

If self-employed, are you covered under the State Disability Insurance Plan? Yes \_\_\_\_\_ No \_\_\_\_\_

If you answered yes to any of the above, please provide full details below (amount, elimination period, benefit period, etc.) \_\_\_\_\_

If you answered yes to any of the above, please provide details below (actual net worth, actual unearned income, sources, amount of bonus each year, etc) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you a permanent resident/citizen of the United States? Yes \_\_\_\_\_ No \_\_\_\_\_

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