The Dearborn Agency

"We make Life Easy"

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1-800-614-1269

support@thedearbornagency.com

Date: ____________

Check One: Deliver _____ Pick-Up _____ Call _____ Fax _____ Mail _____

Broker: ______________________________

Address: ______________________________

____

Telephone#: ____________________ Fax#: ____________________

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Applicant: ______________________________ DOB/AGE: ____________

Resident State: ________ Male [ ] Female [ ] Smoker [ ] Nonsmoker [ ] Other Tobacco [ ]

Occupation: ______________________________ % Ownership: ____________

Years at Occupation: ____________________

Related Education & Certifications: ______________________________

# of Employees: ____________

Office in Home: Yes [ ] No [ ] Exact Duties ____________________

Annual Income: $ ____________ Plan/Policy ____________________

Existing Coverage: Yes [ ] No [ ]

If Yes: Benefit Amt: Base: $ ____________ SIS: $ ____________

Elimination Period: ____________ Benefit Period: ____________

Employee/Employer Paid: ____________ Contributing to SS: Yes [ ] No [ ]

Group or Individual ____________

****

Plan Type: DI [ ] Overhead Expense [ ] Buy/Sell [ ]

Monthly Benefit: $ ____________ EP [ ] BP [ ]

FIO Update: YES [ ] NO [ ] COLA: YES [ ] NO [ ] Residual: YES [ ] NO [ ]

OWN OCC: YES [ ] NO [ ] Other Options: ____________________

Important Health Info ______________________________