

SEQUOIA PREMIER PARTNERS
Individual/BOE Quote Request Form

Phone: (866) 717-8595 Fax: (866) 499-0454 Email: Ron@sppartners.com

Agent Information Name: _____ Date: _____
Phone: _____ Fax #: _____ Email: _____
Producer's Social Security No.: _____

Client Information

Circle appropriate:

Name: _____ Male Female
Date of Birth: _____ Tobacco Use: Yes No
Resident State: _____ Works: _____
Occupation: _____ Title: _____
Duties: _____
Annual Salary: \$ _____ Bonus: \$ _____ Unearned: \$ _____
Commissions: \$ _____ (Three year average)
Government Employee? Yes No
Independent Contractor, Self-Employed, or Business Owner? Yes No
Net Income (After Expenses): \$ _____ Works from Home: Yes No
No. of Years as Owner: _____ If less than 1 Full Year: _____
Former Position / Duties: _____ Former Salary: _____
Circle one: C-Corp S-Corp Partnership LLC No. of Full Time Employees: _____

Individual Case Design:

Benefit Amount: \$ _____ or MAX Premium Payer: Employer: _____ % Employee: _____ %
Elimination Period(s): _____ Benefit Period(s): _____
Options: Partial / Residual Cost of Living: _____ Future Purchase Rider: \$ _____
Automatic Increase: _____ Retirement Plan Deferral: \$ _____
Other Requests:

*To better enable the process, please fax or email request at least 24 hours before needed.
Any missing information will delay the process. Thank you for your business*

Business Overhead Expense Case Design

Monthly Expenses: \$ _____ Elimination Period: _____

Benefit Period: 12 months ___ 18 months ___ 24 months ___ Show Alternatives ___

Options

Partial / Residual: _____ Future Purchase Option: _____ Professional Replacement: _____

In-force BOE Coverage Amount: _____ Replacing: Yes No

Coverage In-Force (Check All That Apply)

Individual: _____ Group LTD: _____ Combination: _____ None: _____

Group LTD Carrier: _____ Replacement %: _____ Benefit Maximum \$: _____

Premium Payer: Employer: _____ % Employee: _____ %

Income Covered: _____

Salary: _____ Overtime: _____ Bonus: _____ Commissions: _____ Retirement Contributions: _____

Benefit Amount: \$ _____ Waiting Period: _____ Benefit Period: _____

Individual DI: Carrier: _____ Benefit Amount: \$ _____

Waiting Period: _____ Benefit Period: _____ Taxable Benefits: Yes No Replacing: Yes No

Is there competition on the case?

Any special Health Conditions or Hospitalizations in the last 5 years? If yes, please explain:

Are you taking any Medications? What is your Height and Weight?

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