United Underwriters Inc.

Quote Request for
DISABILITY INCOME INSURANCE

E-MAIL to jphilibotte@uuinc.com or FAX to 603-778-7918

Date Requested: _____ / _____ / _____

Producer Information:

Name: _____ E-mail: _____

Phone: _____ Fax: _____

Method you would like the quote returned to you: □ E-mail □ Fax □ Broker Pick-Up

Client Information:

Name: _____ Date of Birth: _____ / _____ / _____ □ Male / □ Female

State of Residence: _____

Health Class: □ Preferred □ Standard Height: _____' _____" Weight: _____ lbs.

Ever used tobacco products? □ No □ Yes, type: □ Cigarettes □ Cigar □ Pipe □ Chewing Tobacco

If quit, when: _____

List any medical problems: _____

_____

List any medications & dosages: _____

_____

Business Owner? □ No □ Yes, years of ownership: _____ # of full-time employees: _____ work out of home? □ No □ Yes

Occupation: _____

Job Duties: _____

Taxable Earned Income for this year: $ _____ Taxable Earned Income for last year: $ _____

Existing Coverage: $ _____ □ Individual □ Group □ Personal

Coverage Needs:

□ Long Term □ Short Term Plan Type: □ Personal □ Business Overhead □ Buy/Sell

Elimination Period: _____ days Benefit Period: □ 2 years □ 5 years □ 10 years □ age 65 □ age 67

Quote Amount: □ Quote Maximum □ Quote Desired Monthly Benefit Amount: $ _____

Optional Benefits: □ Cost of Living □ Other: _____

Other Information: _____

_____

_____