DISABILITY INSURANCE WORKSHEET

This is a fillable form. If you fill it out electronically - save the file and return it by email.
If you print it out and fill it out manually - scan it and return it by email or fax to 503-467-5567

First Name	M.I.	Last Name	Gender	Birth Date

Birth Place (city & state)	Social Security #	Drivers License #	Marital Status	Occupation & Duties

Earned Income (salary, bonus & share of business profit)	Other Income (rent, dividends, capital gains etc.)	Net Worth Including Business Value	Personal Liabilities

Home Address	City	State	Zip	Years At Address	Home Phone
Business Name & Address	**City**	**State**	**Zip**	**Years w/employer**	**Business Phone**

EXISTING DISABILITY INSURANCE POLICIES								
Types: I = Individual G = Group A = Association								
Company	Policy #	Issue Yr.	Type I,G,A	Monthly Benefit	Benefit Period	Waiting Period	Does employer pay premiums?	Replace?
							❑ Yes ❑ No	❑ Yes ❑ No
							❑ Yes ❑ No	❑ Yes ❑ No
							❑ Yes ❑ No	❑ Yes ❑ No

1. List your exact duties:_____

2. What percentage of your duties include physical activity such lifting, climbing, crouching, etc? ____%

3. How long have you been employed at your current job? _____ Years
   If less than 2 years, list previous occupation & duration: _____

4. Do you plan to change your occupation? ❑ Yes ❑ No

5. Have you been actively at work on a full-time basis (minimum 30 hours per week)
   for the past 90 days (disregard vacation & normal non-working days)? ❑ Yes ❑ No

6. Have you been homebound or hospitalized due to injury or sickness
   in the past 90 days? ❑ Yes ❑ No

7. How many days have you missed due to injury or sickness in the past 90 days? _____

8. Are you currently disabled and/or collecting benefits? ❑ Yes ❑ No

9. Do you intend to travel outside of the U.S. or Canada in the next 2 years? ❑ Yes ❑ No
   If yes, please provide destination, departure date & return date: _____

10. In the past 3 years, have you taken part in any avocation such as parachute jumping,
    hang gliding, skin or scuba diving? Is such activity planned? ❑ Yes ❑ No

11. In the past 3 years, have you been in a motor vehicle accident, charged with a moving
    violation of any motor vehicle law, or has your drivers license ever been suspended? ❑ Yes ❑ No

12. Is any application or reinstatement for disability, accident or health insurance pending? ❑ Yes ❑ No

13. Will your employer continue your salary or income if you become disabled? ❑ Yes ❑ No
    If yes, amount per month: _____ for _____ months

14. What is your employment status?

❑ Business Owner OR ❑ Employee (no ownership)

Annual salary & Bonus: $_____ Annual Salary & Bonus: $_____

Annual business profit: $_____

Ownership percentage: _____%

Number of full-time employees: _____ Yr Established: _____

❑ Sole Proprietor ❑ S-Corporation ❑ C-Corporation

❑ Partnership – How many partners? _____

❑ LLC – How many members? _____

15. Please complete this section if you work from your home.
    a. Number of years with current business: _____
    b. If less than 2 years, please describe your experience in this field:

       _____

       _____
    c. Number of hours worked weekly: _____
    d. Percentage of time spent working from home vs. at client's site:_____
    e. Frequency of outside contact with clients: _____
    f. Are clients seen in residence? _____
    g. Do you have any contracts in force?_____
    h. Are contracts short or long term?

       _____

       _____

16. Have you ever received treatment for or been diagnosed as having or had any of the following (if Yes, check condition and provide details in comments section)? ❑ Yes ❑ No

❑ Chest Pain	❑ Asthma	❑ Hepatitis
❑ High Blood Pressure	❑ Allergy	❑ Venereal Disease
❑ Heart Attack	❑ Pneumonia	❑ Anxiety
❑ Stroke	❑ Emphysema	❑ Depression
❑ Diabetes	❑ Arthritis	❑ Psychological Disorder
❑ AIDS	❑ Rheumatologic Disorder	❑ Psychiatric Disorder
❑ HIV	❑ Physical Impairment	❑ Fibromyalgia
❑ Tumor	❑ Seizure	❑ Chronic Fatigue Syndrome
❑ Cancer	❑ Paralysis	❑ Parkinson's Disease
❑ Colitis	❑ Epilepsy	❑ Prostate Disorders
❑ Sleep Apnea	❑ High Cholesterol	

17. Have you ever had any disorder of the following? ❑ Yes ❑ No
(if Yes, check condition and provide details in comments section)?

❑ Blood	❑ Bones	❑ Gastrointestinal System
❑ Lymph Nodes	❑ Joints	❑ Liver
❑ Blood Vessels	❑ Eyes	❑ Kidney
❑ Skin	❑ Ears	❑ Genitourinary System
❑ Neck	❑ Heart	❑ Immune System
❑ Back	❑ Lungs	❑ Nervous System
❑ Spine	❑ Breasts	

18. Height: _____ Weight: _____
19. Latest cholesterol readings (if known) Total: _____ LDL: _____ HDL: _____
20. Latest blood pressure reading (if known): _____ / _____
21. Have you ever smoked cigarettes or used other nicotine products? ❑ Yes ❑ No If so, type of nicotine: _____Date of last use?_____
22. Have you applied for insurance in the past year? ❑ Yes ❑ No
23. Have you ever been declined or rated for insurance? ❑ Yes ❑ No
24. Have you ever filed for bankruptcy? ❑ Yes ❑ No
25. Have you ever been convicted of a felony? ❑ Yes ❑ No
26. Have you ever requested or received a pension, benefits or payments because of an injury, sickness or disability? ❑ Yes ❑ No
27. Have you ever received treatment in relation to alcoholism, use of alcohol or controlled substance? ❑ Yes ❑ No
28. Have you ever used barbiturates, narcotics, cocaine or other controlled substance not prescribed by a physician? ❑ Yes ❑ No
29. Do you fly airplanes? ❑ Yes ❑ No If yes, Instrument rated: ❑Yes ❑No # of total solo hours: _____ Avg annual solo hours: _____
30. Do you regularly exercise 3 or more times per week? ❑ Yes ❑ No If yes, what types of exercise:_____

31. Please list all medications currently prescribed.

Prescription	Dosage	Frequency	Reason

32. Please list the following information regarding your personal physician, specialists & hospital visits:

Name	Address & Phone Number	Date Last Seen	Reason & Treatment

33. Other than above, within the **past 5 years** have you had any illness, infection, injury, surgery, physical exam, medical consultation, counseling, electrocardiogram, x-ray or laboratory study, or been a patient in a hospital or other medical facility (if yes please provide details in comments section) ❑ Yes ❑ No

34. Family medical history:

	Age If Living	Age at Death	Heart Disease History?	Cancer History?
Father	_____	___ cause _____	❑ No ❑ Yes age onset _____	❑ No ❑ Yes age onset ___ Type_____
Mother	_____	___ cause _____	❑ No ❑ Yes, age onset _____	❑ No ❑ Yes age onset ___ Type_____
Sibling	_____	___ cause _____	❑ No ❑ Yes, age onset _____	❑ No ❑ Yes age onset ___ Type_____
Sibling	_____	___ cause _____	❑ No ❑ Yes, age onset _____	❑ No ❑ Yes age onset ___ Type_____

Please provide details regarding any "Yes" answers and applicable medical conditions: