In order to assess the financial effect of a disability on your income, you will need to complete this data collection form and the Personal Client Data form.

Disability Insurance

List all disability insurance policies. Along with personal policies, include group policies from work, associations and other sources.

Policy Name/# and Type (i.e., personal, group)	Insured	Monthly Benefit	Annual Premium	Elimination Period	Benefit Period		COLA
DI1 ___	☐ CL-A ☐ CL-B	$ ___ ☐ Taxable	$___	___ days	☐ days___ ☐ years___	☐ Age ___ ☐ Lifetime	___%
DI2 ___	☐ CL-A ☐ CL-B	$ ___ ☐ Taxable	$___	___ days	☐ days___ ☐ years___	☐ Age ___ ☐ Lifetime	___%
DI3 ___	☐ CL-A ☐ CL-B	$ ___ ☐ Taxable	$___	___ days	☐ days___ ☐ years___	☐ Age ___ ☐ Lifetime	___%
DI4 ___	☐ CL-A ☐ CL-B	$ ___ ☐ Taxable	$___	___ days	☐ days___ ☐ years___	☐ Age ___ ☐ Lifetime	___%

Interview Questions

How long could you and your family survive financially if you were to become disabled tomorrow? ___

Would your group insurance provide enough income? ___

Disability Income Needs

	Client A Disability	Client B Disability
Include Social Security Benefits	☐ Yes	☐ Yes
Age Non-Disabled Client Receives Social Security	___	___

	Client A Disabled			Client B Disabled		
Beginning	Monthly Need	Client B Earnings	Other Income	Monthly Need	Client A Earnings	Other Income
After 30 Days	$	$	$	$	$	$
After 90 Days	$	$	$	$	$	$
After 1 Year	$	$	$	$	$	$
After 2 Years	$	$	$	$	$	$
After 5 Years	$	$	$	$	$	$
After Age 65	$	$	$	$	$	$

Increase Need By ___ %

Your Preferences

What percent of your total monthly income would be needed should you become disabled? (e.g., 70%., 85%) ___ %

Declaration

I declare that I have reviewed the information collected in this data sheet and that the investment data is correct to the best of my knowledge.

Client A Printed Name	Signature	Date
Client B Printed Name	Signature	Date

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