Robert Ellis & Associates
Insurance Services

# DISABILITY INCOME INSURANCE
# PREMIUM INDICATION FORM

**To obtain a short or long term disability insurance quote for you and your firm, please complete this Disability Income Insurance Premium Indication Form and return it by fax to 985-674-3881**

| | | |
|---|---|---|
| Name | | |
| Name of Firm | | |
| Address | | |
| City | State | Zip |
| Phone Number | E-mail | |
| Date of Birth | Gender ❑ Male ❑ Female | |

Are you currently a member of:

❑ The Mississippi Dental Association
❑ The Mississippi Society of Certified Public Accountants
❑ The Mississippi Association for Justice
❑ Louisiana Dental Association
❑ Louisiana Pharmacists Association
❑ Capital Area Medical Society

Please indicate the coverage you are interested in: ❑ Individual ❑ Firm

Please list you and your employees below

| NAME | DATE OF BIRTH | GENDER | OCCUPATION | ANNUAL SALARY |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

If you require additional space to list employees, please attach separate sheet.

**BENEFIT OPTIONS**

Select below the benefit plans for which you would like to receive a premium quote and benefit highlights

Monthly benefit requested $_____

Benefit duration requested: ❑ 5 years ❑ to age 65
Waiting peroid: ❑ 30 days ❑ 60 days ❑ 90 days