



**BEST VALUE
INSURANCE
AGENCY, INC.**

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Disability and Accident Insurance Questionnaire

Personal Information

Name: _____ DOB: ___/___/___
Street Address: _____ City: _____ State: ___ Zip Code: _____
Home Phone: (____) ____-____ Work Phone: (____) ____-____ Email Address: _____
Occupation: _____ Occupation Class: 1A 2A 3A 4A
Monthly Income: \$_____ Tobacco: Yes No
Height: _____ Weight: _____

Current Disability Coverage

Individual: Yes No Group: Yes No
Elimination Period: _____ Benefit Period: _____

Medical Information

Current Medication	Dosage	Reason for Medication

- Have you ever had any of the following:
Cancer Heart Problems Back, bone, or spine problems
Diabetes Arthritis High blood pressure
- Do you engage in hazardous sports? Yes No
- Have you ever made a claim for disability or Workman’s Compensation? Yes No

Desired Coverage

- Monthly Benefit Amount: \$_____
- Waiver of Premium Rider? Yes No
- Return of Premium? Yes No



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