Instructions:

1. Download to desktop
2. Complete form
3. Save
4. Submit by clicking top right button

SUBMIT

Long-term Disability Insurance Quote Request Form

Name:_____

Occupation:_____

Self Employed: ☐ Y ☐ N

Annual Salary: _____

Existing Long-term Disability Coverage: ☐ Y ☐ N

If yes, what is the monthly benefit? _____

State of Residence: _____

Date of Birth: _____

Gender: ☐ M ☐ F

Height: _____ **Weight:** _____

Tobacco Use: ☐ Y ☐ N

Phone: _____ **Email Address:**_____

Have you ever been treated for or diagnosed with any of the following? (Check all that apply)

☐ Heart Disease	☐ Cancer	☐ Sleep Apnea
☐ COPD	☐ High Cholesterol	☐ High Blood Pressure
☐ Diabetes	☐ Asthma	☐ Alcohol/Drug Use
☐ Depression	☐ Anxiety	☐ Neck/Back Disorder
☐ MS	☐ Currently Pregnant	☐ High Liver Enzymes

Please provide details and any medications you are currently taking.

Return to:
The MPM Group
Phone: (859) 223-4973 I Fax: (859) 224-1288 I Email: dbaldwin@thempmgroupllc.com