DISABILITY
DISCOVERY QUESTIONNAIRE

THIS IS FOR QUOTATION PURPOSES ONLY – THIS IS NOT A BINDER **SIC CODE #:**_____

Complete the following information if you would like to obtain a quote on Disability Insurance. Please understand this is not an application for insurance. An application will be sent to you if coverage is desired.

All information provided on this information sheet is confidential and will be used solely for the purpose of developing a quote for you.

PERSONAL INFORMATION

1. Name: _____
2. Mailing Address _____
   City: _____ State: _____ Zip: _____
3. Phone: _____ Fax #: _____ E Mail: _____
4. What is your birth date? _____ What is your gender? ☐ M ☐ F
5. What is your height? _____ What is your weight? _____ What is your marital status? _____

UNDERWRITING INFORMATION

All YES answers please explain in remarks below:

1. Do you have a pilot license of any type? ☐ Yes ☐ No
2. If Yes, What type? _____
3. Do you participate in scuba diving, any racing, mountain climbing, hand-gliding, skydiving, etc.? ☐ Yes ☐ No
4. Have you had your driver's license suspended or revoked? ☐ Yes ☐ No
5. Have you been convicted of a felony? ☐ Yes ☐ No
6. Have you received disability compensation? ☐ Yes ☐ No
7. Have you been advised by a physician to reduce your alcohol consumption? ☐ Yes ☐ No
8. Do you smoke or chew tobacco? ☐ Yes ☐ No
9. Have you used LSD, cocaine or any illegal narcotics? ☐ Yes ☐ No
10. Is your health impaired in any way? ☐ Yes ☐ No
11. Are you taking medication? ☐ Yes ☐ No

12. Do you have high blood pressure? ☐ Yes ☐ No
13. Do you have asthma, emphysema, or respiratory problems? ☐ Yes ☐ No
14. Do you have cancer or other tumors? ☐ Yes ☐ No
15. Do you have diabetes? ☐ Yes ☐ No
16. Do you have AIDS; HIV? ☐ Yes ☐ No
17. Are you pregnant? ☐ Yes ☐ No
18. Have you ever been declined life, health or disability insurance? ☐ Yes ☐ No
19. Are you a U.S. citizen? ☐ Yes ☐ No

Remarks: _____

COVERAGE INFORMATION

1. What is your annual gross salary, including tips, fees and commissions? $_____
2. How long have you been employed at your present occupation? _____
3. What percentage of your income do you want your disability policy to cover?
   ☐ 50% ☐ 60% ☐ 65% ☐ 70%
4. How long do you want the elimination period to be (the length of time you must be disabled before you start to receive benefits? ☐ 30 days ☐ 60 days ☐ 90 days ☐ 6 months ☐ 1 year ☐ 2 years
5. How long do you want the benefit period to be (the maximum length of time you will receive benefits after you have been classified as being disabled and satisfied the elimination period)?
   ☐ 2 years ☐ 3 years ☐ 4 years ☐ 5 years ☐ Until the age 65.
6. Are you self-employed? ☐ Yes ☐ No
7. What is your occupation? _____
8. Please describe briefly your duties at your current job. _____
9. Is there a particular reason why you are purchasing disability insurance? ☐ Yes ☐ No
   If Yes, please explain: _____

10. Do you have disability insurance now? ☐ Yes ☐ No

11. If Yes, how much do you have now? $_____

Questions or Comments: _____

_____

_____

_____

Please let us know the best time to call and discuss your quote:

☐ Morning ☐ Afternoon ☐ Evening ☐ Anytime ☐ Other:_____

NOTICE OF INSURANCE PRACTICES:

Personal information about you may be collected from persons other than you. Such information as well as other personal and privileged information collected by us or the agents may in certain circumstances be disclosed to third parties. You have the right to review your personal information in our files and can request corrections of any inaccuracies. A more detailed description of your rights and our practices regarding such information is available upon request. Contact your agent/broker for instructions on how to submit a request to us.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON, FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

_____ _____

Signature Date

STATE LICENSED AGENT
F. DARRELL LINDSEY – ALL STATES
P. O. Box 526357
Salt Lake City, UT 84152-6357
PH: 866-937-7037
FX: 866-937-7010
E-Mail: fdl@LLLindsey.com

California Office License No#: OC13511 – Robby L. Lindsey
Other States: F. Darrell Lindsey – See U.S. Map on the Web Site

FRAUD WARNING

NOTICE TO ALL STATES INCLUDING SPECIAL NOTICE TO ARKANSAS, COLORADO, FLORIDA, KENTUCKY, MAINE, MINNESOTA, NEW JERSEY, NEW MEXICO, NEW YORK, OHIO AND PENNSYLVANIA APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND MAY BE SUBJECT TO SUBSTANTIAL CIVIL FINES AND CRIMINAL PENALTIES."

REPRESENTATIONS AND WARRANTIES

The "Applicant" is the party to be named as the "Insured" in any insuring contract if issued. By signing this Application, the Applicant for insurance hereby represents and warrants that the information provided in the Questionnaire, together with all supplemental information and documents provided in conjunction with the Application, is true, correct, inclusive of all relevant and material information necessary for the Insurer to accurately and completely assess the Application, and is not misleading in any way. The Applicant further represents that the Applicant understands and agrees as follows: (i) the Insurer can and will rely upon the Application and supplemental information provided by the Applicant, and any other relevant information, to assess the Applicant's request for insurance coverage and to quote and potentially bind, price, and provide coverage; (ii) the Application and all supplemental information and documents provided in conjunction with the Application are warranties that will become a part of any coverage contract that may be issued; (iii) the submission of an Application or the payment of any premium does not obligate the Insurer to quote, bind, or provide insurance coverage; and (iv) in the event the Applicant has or does provide any false, misleading, or incomplete information in conjunction with the Application, any coverage provided will be deemed void from initial issuance.

The Applicant hereby authorizes the Insurer and its agents to gather any additional information the Insurer deems necessary to process the Application for quoting, binding, pricing, and providing insurance coverage including, but not limited to, gathering information from federal, state, and industry regulatory authorities, insurers, creditors, customers, financial institutions, and credit rating agencies. The Insurer has no obligation to gather any information nor verify any information received from the Applicant or any other person or entity. The Applicant expressly authorizes the release of information regarding the Applicant's losses, financial information, or any regulatory compliance issues to this Insurer in conjunction with consideration of the Application.

The Applicant further represents that the Applicant understands and agrees the Insurer may: (i) present a quote with a sub-limit of liability for certain exposures, (ii) quote certain coverage(s) with certain activities, events, services, or waivers excluded from the quote, and (iii) offer several optional quotes for consideration by the Applicant for insurance coverage. In the event coverage is offered, such coverage will not become effective until the Insurer's accounting office receives the required premium payment.

The Applicant agrees that the Insurer and any party from whom the Insurer may request information in conjunction with the Application may treat the Applicant's facsimile signature on the Application as an original signature for all purposes.

Dated: _____	Dated: _____
Applicant:	Agent/Broker:
_____	_____
Signature	Signature
_____	_____
Print Name	Print Name

F. Darrell Lindsey State Licensed Producer/Broker	**STATEMENT OF NO KNOWN CLAIMS / CIRCUMSTANCES**

A

Note: This statement must be signed and returned with the completed application.

The signature below confirms that:

- **I have no known losses or claims that have not been reported to my prior insurance carrier or any other financial risk transfer source from which payment might be made;**
- **I have no knowledge of facts or circumstances that relate to a medical incident(s) arising from professional services which could reasonably result in a claim, that has not been reported to a prior insurance carrier;**
- **I have no knowledge of any request for medical records by a patient or his/her attorney, which might result in a claim;**
- **I have no knowledge or information relating to service or services on a Board, which might result in a claim; and,**
- **I have no knowledge of any prior professional liability carrier refusing coverage for, or demanding to accept a report of a medical incident, threat of claim, letter of intent, adverse result notice or attorney contact.**

The applicant declares that the information contained herein is accurate and that no material facts have been suppressed. The applicant understands and acknowledges that the information contained in the application is deemed material and that any policy issued by the Company is done so in reliance upon the truth of the applicant's representations. The applicant understands that incorrect information could void coverage.

Signature: _____ **Date:** _____

Printed Name: _____

Witness: _____ **Date:** _____

Printed Name: _____

LLL Insurance Services
P.O. Box 526357
Salt Lake City, Utah 84152-6357
PH: 866-937-7037 / FX: 866-937-7010

F. Darrell Lindsey State Licensed Producer/Broker	**STATEMENT OF NO KNOWN CLAIMS / CIRCUMSTANCES**

B

Note: This statement must be signed and returned with the completed application.

The signature below confirms that:

- **I have no known losses or claims that have not been reported to my prior insurance carrier or any other financial risk transfer source from which payment might be made;**
- **I have no knowledge of facts or circumstances that relate to any incident(s) arising from our business operations or services which could reasonably result in a claim, that has not been reported to a prior insurance carrier;**
- **I have no knowledge of any request for records from any attorney, which might result in a claim;**
- **I have no knowledge of any prior insurance carrier refusing coverage because of the threat of a claim, letter of intent to file a claim, or adverse result notice or attorney contact about a claim.**

The applicant declares that the information contained herein is accurate and that no material facts have been suppressed. The applicant understands and acknowledges that the information contained in the application is deemed material and that any policy issued by the Company is done so in reliance upon the truth of the applicant's representations. The applicant understands that incorrect information could void coverage.

Signature: _____ **Date:** _____

Printed Name: _____

Witness: _____ **Date:** _____

Printed Name: _____

LLL Insurance Services
P.O. Box 526357
Salt Lake City, Utah 84152-6357
PH: 866-937-7037 / FX: 866-937-7010

F. Darrell Lindsey U.S. Licensed Producer/Broker	**CLAIM INFORMATION SUPPLEMENT** **SEPARATE FORM FOR EACH SEPARATE CLAIM**

This Claim Information Supplement must be completed, signed and dated by the applicant for each claim, suit or circumstance reported on your application for insurance. All questions must be answered completely. If any question does not apply, indicate NOT APPLICABLE. If space is not sufficient to properly answer the question, please attach a separate page. Photocopy this form and use a separate one for each claim, suit or circumstance.

Information:

Name:	Social Security Number or Corp. Number

Claim or Circumstance Information

Claimant Name:	Age:	Sex:
Date of Alleged Incident:	Date Claims was made or Suit Brought:	
Additional Defendants:		
Insurance Carrier to Whom Claim/Circumstance Reported:		

Claim Status if Liability:

DISMISSED		DEFENSE VERDICT
PLAINTIFF VERDICT	TOTAL PAID $	PAID ON YOUR BEHALF $
SETTLEMENT	TOTAL PAID $	PAID ON YOUR BEHALF $
OPEN		
Settlement Demand $	Settlement Offer $	Loss Reserve $

Claim Status if Property:

Demand Made: $	Status if not closed; Explain:
Settlement Amount: $	

For all Paid and Reserve amounts, include both Indemnity and Expense dollars.

Claim Description: Include allegation(s), events leading up to the claim, and any other facts pertinent to the claim.

PLEASE EXPLAIN: What BUSINESS PRACTICES or RISK MANAGEMENT procedures have you developed and effected to prevent a claim like this in the future? Note any changes, like hiring procedures, client screening, signed disclosure of risk forms, JOB work orders signed, inspections of jobs completed, employee training, etc.. Explain in your own words: _____

_____

_____

_____

The applicant declares that the information contained in this CLAIM INFORMATION SUPPLE-MENT is true and that no material facts have been suppressed or misstated. The applicant under-stands and acknowledges that the information contained in the application is deemed material and that any policy issued by the Company is done so in reliance upon the truth of the applicant's representations. The applicant understands that incorrect information could void coverage.

Signature: _____ **Date:** _____

Printed Name: _____

Witness: _____ **Date:** _____

LLL Insurance Services
P.O. Box 526357
Salt Lake City, Utah 84152-6357
PH: 866-937-7037 / FX: 866-937-7010

F. Darrell Lindsey U.S. Licensed Producer/Broker	**CLAIMS HISTORY WARRANTY** **REPLACES INSURED'S FIVE-YEAR LOSS RUNS**

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON, FILES AN APPLICATION FOR INSURANCE CONTAINING FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY MATERIAL FACT THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THE PERSON TO CRIMINAL AND CIVIL PENALTIES.

Business Name: _____

It is understood and agreed that in lieu of the required insurance company loss runs required to document the state of prior Loss History of the named insured, the following statement of prior claims will be accepted as a supplement to the application information and will also serve as a warranty statement to be made a part of any policy issued.

Policy Year	Date of Loss	Description of Loss	Amount Paid

PLEASE ADVISE: If you are reporting NO claims; please explain the business practices and risk management procedure you have taken; LIKE; like special hiring procedures, screening new clients, job inspections, signed acknowledgement of risk forms, requiring signed work orders, employee training, etc., THAT YOU BELIEVE HELP prevent the filing of claims? Explain in your own words:

_____

_____

_____

_____

If necessary, additional Loss History and Warranty Forms can be used to complete the required five-year history.

The insured must sign each separate completed form.

As the Named Insured, I warrant that the above loss history represents all claims, loses and accidents, of any kind, in which the Named Insured has direct knowledge.

Authorized Signature	Please Type or Print Name	Date
Witness's Signature	Witness's Name	Date

F. Darrell Lindsey U.S. Licensed Producer/Broker	**ADDITIONAL INFORMATION FORM**

Please use the space provided below to provide additional information as required by individual questions in this application. Use additional sheets if necessary.

Question #	COMMENTS