Fillable Forms Requirements

This form (PDF) requires the use of Acrobat Reader to edit and save changes.

I have Acrobat Reader installed:

- Simply open the fillable form in Acrobat Reader, make your changes, save, and email back to the sender.

I don't have Acrobat Reader installed:

- Download the free version here https://get2.adobe.com/reader/otherversions/ and follow the on-screen instructions to install the program.
- Once installed, reopen this PDF file to have it automatically open in Acrobat Reader.
- Finally, please make your changes, save, and email back to the sender.

Disability

Instructions

Personal information: Enter your name, date of birth, and annual salary.

	Name	DOB	Annual Salary
Client 1			
Client 2			

Current Insurance

List the benefits provided by any existing insurance that you may have.

	Monthly Benefit	Elimination Period	Benefit Period	COLA Rate
Client 1		1 Month	3 Months	%
Client 1		1 Month	3 Months	%
Client 2		1 Month	3 Months	%
Client 2		1 Month	3 Months	%

Contact Information
Address:
Phone: