Policy Number_________________ Date_____/_____/______

Occupation Questionnaire

Name:_____________________________________ D.O.B. _____/_____/___________

1) What is you job title? ____

2) What are your specific duties and responsibilities? _____________________________________
____
____
____

3) What is the name of your firm/employer? ____

4) What type of business is your firm/employer? ______________________________________

5) How long have you been in your current position? __________________________________

If less than 3 years, what was your prior occupation? _____________________________

What were your previous duties/responsibilities? _________________________________
____
____

6) How many hours per week do you work? ____

7) What is your current annual income? $ ____

8) Have you ever been denied disability income coverage? Yes No
If yes, please provide details____
____

9) Have you ever been disabled or collected Workmen's Compensation Benefits? Yes No
If yes, please provide details: ____
____
____
____
____

I hereby declare that the above information is true to the best of my knowledge:

Signature of Proposed Insured: _____________________________ Date: _____/_____/______

Agent: ____________________________________ Agent Writing Number: _______________

Agent Signature: ____ Date: ____/_____/________

Fax to Rohrer & Associates at 608-756-0048