



FINANCIAL QUESTIONNAIRE
 SUPPLEMENT TO REQUEST FOR DISABILITY COVERAGE

APPLICANT'S NAME: _____

(Please print)

If any question does not apply, indicate "NA".

TOTAL NET WORTH (Liquid Assets minus Liabilities): \$ _____

TOTAL ANNUAL UNEARNED INCOME
 (As reported to IRS - e.g. Interest, Dividends, Royalties, Rental Income etc.) \$ _____

I. IF EMPLOYED: Annual Salary = \$ _____

II. SELF – EMPLOYED – Complete all sources of income:

A. SOLE PROPRIETOR or PARTNER
 Gross earned income (share of partnership income)
 Past 12 months or fiscal year ending: _____
 (Gross earnings before business expenses and taxes) \$ _____

Total business expenses for above period (your share) - \$ _____

Net earned income, before personal income tax: = \$ _____

B. PROFESSIONAL CORPORATION
 Annual salary drawn currently \$ _____
 Your share of S-Corp distribution, if any + \$ _____
 Your share of dividends + \$ _____
 Payment of bonus + \$ _____

▪ Was bonus a one-time payment or annual payment

Payment of commission + \$ _____

▪ Was the commission a one-time payment or annual payment

Annual Cost of corporate-paid benefits (e.g. Life or Health Insurance premiums, pension or profit sharing trust contributions paid on your behalf): + \$ _____

Total annual earned income: = \$ _____

How long have you been self-employed? _____

Are you working out of your home? _____ If "yes" is any work conducted outside of the home? _____
 Please explain and/or provide details including average number of days per week clients are seen

III. DISABILITY INSURANCE IN FORCE - INCLUDE ANY GROUP DISABILITY BENEFITS:
 Company: _____ Benefit: _____ Elimination Period: _____ Maximum Benefit Period: _____

IV. DISABILITY INSURANCE APPLIED FOR WITH ANOTHER OR COMPANIES:
 Will coverage applied for with us replace any of the above? **YES** _____ **NO** _____
 (If so, indicate which, and date it will be terminated) _____

I understand that any insurance issued will be in consideration of the answers and statements provided on this form which supplements my request for group insurance and on any other form(s) or documents signed by me and made part of the certificate of insurance, if issued. I also understand insurance may be invalidated if New York Life finds that I have not answered the questions on this form truthfully and completely.

Signature of Applicant _____ Date _____

Signature of Accountant (Optional unless requested) _____ Date _____