New York Life Insurance Company
– A Mutual Company Founded in 1845 –
51 Madison Avenue, New York, NY 10010

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 _________________