

# Let's Insure

## Disability Insurance Form

Tel: (877) 851-7867, Fax: (888) 414-8280, [Info@LetsInsure.org](mailto:Info@LetsInsure.org)

First and Last Name	Date of Birth	Gender		Occupation
		Male	Female	
Occupational Duty			What percentage of time you spend on this duty	%
Occupational Duty (second option)			What percentage of time you spend on this duty	%
Are you self-employed?		Yes	No	Gross Earning (after expenses if you are self-employed)
<b>Medical History</b>				
Have you smoked a cigarette or used a nicotine replacement product in past 12 months?			Yes	No
			If yes, Date	
What is your height?		What is your weight?		
Are you currently taking any medication?		Yes	No	
Are you pregnant?		Yes	No	
<b>Do you have a history of:</b>				
Neck or back disorders	Mental or Nervous conditions	Diabetes	High Cholesterol	Hypertension
<b>In the last 5 years, have you seen any:</b>				
Physicians	Chiropractors	Counselors	Psychiatrists	