

LONG TERM DISABILITY QUESTIONNAIRE

General Information

Group Name _____ Date: _____

Mailing Address _____

City _____ County _____ State _____ Zip _____

Phone Number _____ Fax Number _____

Email Address _____

Current Policy Information

Name of Company _____

Current Plan Design _____

Current Renewal Rates _____

Employee Information

	Type of Cov.	Name	Gender	DOB	Job Title	Date of Hire	Annual Salary
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							

	Type of Cov.	Name	Gender	DOB	Job Title	Date of Hire	Annual Salary
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34							
35							
36							
37							
38							
39							
40							



SCMA Financial Services, Inc.
A subsidiary of the South Carolina Medical Association

1.800.327.1021
803.750.1115 fax
P.O. Box 21667
Columbia, SC 29221