Applicant Information:

Full Name:

Mailing Address:

City:

State: **(Maryland, Virginia or District of Columbia)**

Zip Code:

E mail: **(Required)**

Home Phone: Work Phone: Ext.

How to Contact You: Select One

Date of Birth: (mm/dd/yyyy)

Gender: Select One Height: ft.

Weight: Do you smoke? Select One

Do you currently have disability insurance? Select One

Current Premium:$ per month

Occupation or Title:

Monthly Gross Income:$

Explain Job Responsibilities:

Are you a government employee? Select One

Are you a business owner? Select One

Maryland Disability Insurance Coverage Information:

Length of Disability Coverage Needed? Select One

Maryland Disability Coverage For? Select One

Type of Disability Coverage Needed? Select One

Monthly Benefit Amount Desired: $ Select Amount

Or Enter a Different Monthly Benefit Amount: $

Benefit Period: Select One

Elimination Period: Select One

Payment Mode: Select One

Explain any prior workers comp or serious health issues below.

Additional Information:

**Information received from this Maryland Disability Insurance quote request form sent to Brown Insurance Group, will be for our use only and will not be sold, given to or distributed to any other parties. A quote will be based on the disability insurance policy information provided and does not guarantee acceptance of the risk by us. The precise coverage afforded is subject to meeting underwriting guidelines, and the terms, conditions and exclusions of the policy as issued. By submitting this request you acknowledge that this is neither an offer to insure nor a guarantee of insurance. Completion of this form does not entitle you to a Maryland Disability Insurance Policy. We are licensed in Maryland, Virginia and the District of Columbia, and will not provide quotes for other states.