Voluntary Waiver of Disability Income Coverage

Date: _____

Client Name: _____

Advisor Name: _____

This form is notice that the client hereby acknowledges that they were informed by their advisor about the availability of Disability Income insurance coverage (DI). By way of signing this document, the client, hereby acknowledges that they have made the decision to waive their right to apply for DI coverage at this time and decline the option to complete a DI application.

The client also acknowledges that this is against the advice of their advisor and that by signing this document they are releasing any liability of the advisor by any and all parties who have or may have right to bring claim against any party with regard of the client's decision to voluntary decline the option to apply for DI coverage.

The client fully acknowledges that they have reviewed this document and understand the effect of declining DI coverage.

The client understands that if they desire to apply for DI Insurance at a later date, that the price, availability of product and options for coverage may change for a variety of reasons, including, but not limited to age, health and market conditions.

Client Signature: _____ Date: _____

Client Name (Printed) : _____

Advisor / Witness Signature: _____ Date: _____

Advisor / Witness Name (Printed): _____

Advisor should retain this completed form in their records along with a copy of the recommended Disability Income illustration for a period no less than the life of the client.