



Individual Health Insurance Quote Information

Name:	Phone #:	
Address:	County:	Zip Code:

Name of current insurer?..... _____ Not Insured
 Is this group insurance?..... No Yes
 Current Premium?..... \$ _____

	Name	Date of Birth	Height	Weight	Used tobacco products?	Any health issues?
Primary Insured		/ /	___ ft	___ inches	<input type="checkbox"/> within last 3 years <input type="checkbox"/> never	<input type="checkbox"/> No <input type="checkbox"/> Yes –explain in remarks
Spouse		/ /	___ ft	___ inches	<input type="checkbox"/> within last 3 years <input type="checkbox"/> never	<input type="checkbox"/> No <input type="checkbox"/> Yes –explain in remarks
1 st child		/ /	___ ft	___ inches	<input type="checkbox"/> within last 3 years <input type="checkbox"/> never	<input type="checkbox"/> No <input type="checkbox"/> Yes –explain in remarks
2 nd child		/ /	___ ft	___ inches	<input type="checkbox"/> within last 3 years <input type="checkbox"/> never	<input type="checkbox"/> No <input type="checkbox"/> Yes –explain in remarks
3 rd child		/ /	___ ft	___ inches	<input type="checkbox"/> within last 3 years <input type="checkbox"/> never	<input type="checkbox"/> No <input type="checkbox"/> Yes –explain in remarks
4 th child		/ /	___ ft	___ inches	<input type="checkbox"/> within last 3 years <input type="checkbox"/> never	<input type="checkbox"/> No <input type="checkbox"/> Yes –explain in remarks

What type of coverage are you interested in?
 *Insurance costs increase as you select more comprehensive coverages and low deductibles.

Very Basic with low premium the primary concern
 Comprehensive Major Medical:
 Deductible? \$ _____
 Coinsurance: 80/20 50/50
 with Doctor Visit Copay Option
 with prescription drug coverage
 High Deductible Plans
 Medical Savings Accounts
 Medicare Supplement - Which Plan: A B C D F G

What is your occupation?..... _____ Self-employed?
 What is the occupation of your spouse?..... _____ Self-employed?

Remarks: