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Individual Health Quote Request

The quote you have requested requires that you complete the following survey as completely and accurately as possible. Once submitted the information will be e-mailed to our office and we will expedite your request. This information will be kept confidential and will be used for quote purposes only. We look forward to serving you.

Contact Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Work: _____ Home: _____ Fax: _____

Occupation: _____

Email Address: _____

Type of Coverage

Doctor Visit Copay: Yes ☐ No ☐

Optional Coverage: Maternity ☐ Prescription Card ☐ Supplemental Accident ☐

List any major medical conditions associated with any individual or dependents listed below: (cancer, diabetes, heart) _____

Census Information

Please list all individuals (you, your spouse, and dependents) you wish to cover.

	Name	Date of Birth	Age	Gender		
You	_____	_____	_____	_____		
			Height	Weight	Smoker?	
			_____	_____	_____	
Spouse (if applicable)	_____	_____	_____	_____		
			Height	Weight	Smoker?	
			_____	_____	_____	
Child 1	_____	_____	_____	_____		
			Height	Weight	Smoker?	
			_____	_____	_____	
Child 2	_____	_____	_____	_____		
			Height	Weight	Smoker?	
			_____	_____	_____	
Child 3	_____	_____	_____	_____		
			Height	Weight	Smoker?	
			_____	_____	_____	

If you have more that 3 children, simply submit this form additional times. You will only need to enter your name on the other submissions.

Additional Considerations/Requests

Please give any additional comments you feel appropriate for this quotation. _____