

Individual Insurance Information Sheet

Date Submitted: _____ Information taken by: _____ Referred by: _____

Effective Date: _____ (1) Prospect's Name: _____ Contact Person: _____

Gender: Male / Female DOB: _____ Tobacco: YES / NO Occupation: _____

Address: _____ City: _____ Zip: _____ County: _____

E-mail Address: _____ Single Married Children(#): _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ (1 2) Cell Phone: (____) _____ - _____ (1 2)

Dependent Information

(2) Spouse: _____ M F DOB: _____ Tobacco: YES / NO Occupation: _____

(3) Child: _____ M F DOB: _____ Tobacco: YES / NO

(4) Child: _____ M F DOB: _____ Tobacco: YES / NO

(5) Child: _____ M F DOB: _____ Tobacco: YES / NO

(6) Child: _____ M F DOB: _____ Tobacco: YES / NO

Check the type(s) of coverage to be quoted

Co-pay Requested

* PPO HSA HMO Dental Life Disability STM Supplemental YES / NO

Deductible Requested

Drug Card

\$500-\$3000 \$3250-\$5000 \$5250-\$7000+ YES / NO

Current Coverage: YES / NO

-If YES: Until when? _____ Carrier's Name: _____ Current Premium: \$ _____

-If NO: Is Cobra available to you? YES / NO How long have you been without coverage? _____

Physician/Network Check: List your **current** doctor(s)* using column (#) to correspond to the (1) Applicant (2) Spouse (3) Child (4) Child (5) Child (6) Child

PHYSICIAN'S FULL NAME	#	PROVIDER TYPE (GP, OBGYN, etc)	PHONE NUMBER	CITY & ZIP CODE

Medications List: List ALL PRESCRIPTIONS, include TYPE [Capsules/Tablets/Liquid/Etc.] ,and DOSAGE (NO OVER THE COUNTER OR NON-PRESCRIPTIONS)

*Print additional sheets if needed for provider or medication information

*PPO not available in some counties

Prospect's **Signature** _____

Date _____