

Individual Health Quote Information

Effective Date of Policy: \_\_\_\_\_

Name of Primary Insured: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

Telephone Number: (home) \_\_\_\_\_ (work) \_\_\_\_\_

Profession: (prospect): \_\_\_\_\_ (spouse): \_\_\_\_\_

Participant of Plan: Self; Self and Spouse; Family; Self and Dependents Only;  
Dependents Only

Number of dependents covered under plan: \_\_\_\_\_

\*\*\*\*\*dependents are eligible through the month they marry or the end of the year they  
attain age 18; or age 23 if a full time student

Names of other individuals to be on the policy: Spouse: \_\_\_\_\_

Child 1: \_\_\_\_\_; Child 2: \_\_\_\_\_

Child 3: \_\_\_\_\_; Child 4: \_\_\_\_\_

Date of Birth: Primary Insured: \_\_\_\_\_;

Spouse: \_\_\_\_\_; Child 1: \_\_\_\_\_;

Child 2: \_\_\_\_\_; Child 3: \_\_\_\_\_;

Child 4: \_\_\_\_\_

Tobacco User: YES NO Name(s) of Individual: \_\_\_\_\_  
\_\_\_\_\_

Type of Deductible: 250 500 1000 2500 5000 10000

Type of Coverage: PPO HMO Comp Major Medical Plan Temporary Plan

If Temp Plan: end date of coverage: \_\_\_\_\_

Riders: Maternity                  Dental

\*\*\*\*maternity benefit is available only at the initial time of application

\*\*\*\*dental rider must be purchased for the same number of individuals under the base health policy

Prescription Drug Card: YES    NO

\*\*\*\*only available with 250 and 500 deductibles on the HMO and PPO Plans

Height: Primary Insured: \_\_\_\_\_; Spouse: \_\_\_\_\_; Child 1: \_\_\_\_\_; Child 2: \_\_\_\_\_;  
Child 3: \_\_\_\_\_; Child 4: \_\_\_\_\_

Weight: Primary Insured: \_\_\_\_\_; Spouse: \_\_\_\_\_; Child 1: \_\_\_\_\_; Child 2; \_\_\_\_\_;  
Child 3: \_\_\_\_\_; Child 4: \_\_\_\_\_

Current Treatments and/or medications:

Primary Insured: _____	Spouse: _____
_____	_____
_____	_____
Child 1: _____	Child 2: _____
_____	_____
_____	_____
_____	_____