

Company Name Health Insurance Quote Form

You may complete this form and send it to us using our secure server by clicking on the "Submit" button below or you may fill in the information, print the form from your browser window by clicking "Print Page" button above and mail or fax the form to:



Company Name
Company Address
City, State, Zip
Tel. (555) 555-5555
Fax (555) 555-5555
www.domain.com

* Denotes Required Field

Personal Information

*Name:
*Address:
*City: *State: *Zip Code:
*Day Phone: *Evening Phone: Ex: 920-111-2222
Best Time to Call:
*E-Mail Address:
*Confirm E-Mail Address:

Information About Yourself and Your Family

Please enter information below for all to be covered

	Self	Spouse	Child #1	Child #2	Child #3
Full Name:					
Date of Birth <i>Ex. 01/15/2007:</i>					
Sex:					
Full-Time Student:					
Occupation:					
Height:	Ft. in.	Ft. in.	Ft. in.		
Weight:		Lbs. Lbs.		Lbs.	
Tobacco User:					
Type Used:					
Last Time Used:		Month/Year <i>Ex.03/2007</i>		Month/Year <i>Ex.03/2007</i>	
Have you (they) had (have) any of the following health conditions?:	Heart Cancer Diabetes HBP	Heart Cancer Diabetes HBP	Heart Cancer Diabetes HBP	Heart Cancer Diabetes HBP	Heart Cancer Diabetes HBP

Individual Histories

Please list any individual histories on each person to be covered

Self: **Is person to be insured currently on any prescription medications for ongoing health conditions?**
(Also, please DISCLOSE any and all health conditions you have or have had in the past)

Yes **No** *If yes, please list below*

Spouse: **Is person to be insured currently on any prescription medications for ongoing health conditions?**
(Also, please DISCLOSE any and all health conditions you have or have had in the past)

Yes **No** *If yes, please list below*

Child #1: **Is person to be insured currently on any prescription medications for ongoing health conditions?**
(Also, please DISCLOSE any and all health conditions you have or have had in the past)

Yes **No** *If yes, please list below*

Child #2: **Is person to be insured currently on any prescription medications for ongoing health conditions?**
(Also, please DISCLOSE any and all health conditions you have or have had in the past)

Yes **No** *If yes, please list below*

Child #3: **Is person to be insured currently on any prescription medications for ongoing health conditions?**
(Also, please DISCLOSE any and all health conditions you have or have had in the past)

Yes **No** *If yes, please list below*

Health Coverages

	Self	Spouse	Child #1	Child #2	Child #3
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Add Health Coverage?:

Deductible Desired:

Please check desired coverages below for your health plan

High deductible catastrophic plan

No deductible co-pays

Maternity

HSA (Health Savings Account)

Dental

Vision

Preventative

Other (describe below)

*Please describe **other** desired coverages (not listed above) here:*

Additional Comments

Please provide any additional comments that you feel would be appropriate for this quotation. If you have additional information to provide, where there were not enough fields above; please enter it here:

*Acknowledgement and Consent

I hereby certify that the above information is complete and accurate to the best of my knowledge. The agency receiving this application will retain the application whether or not a policy is issued. The agency may rely on this application when determining the quotation and when deciding whether to issue a policy. False statements may subject me to criminal penalties.

If a policy is issued, I authorize the agency to give information about me to its affiliates.

Yes **No**

***Enter Your Initials Here:**

***Today's Date:**

Ex: 01/12/2007

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