

Last Name: _____

Date: _____ Individual Plan quote sheet

How did you locate us or who referred you?

Name & Occupation

Date of Birth / Height & Weight

Phone #

Fax:

Cell Phone #:

Email:

Spouse Name & Occupation

Date of Birth / Height & Weight

Is everyone a US citizen?

Yes IF NO, does person have a social security #? Yes No

IF NO, How Long is USA? Green Card Holder? Yes No

List any tobacco users:

Anyone pregnant?

Yes

No

List each child to be covered & include sex, date of birth, height & weight

1.

2.

3.

4.

Where do you Live?

City:

Zip Code:

County:

Current health coverage (circle)

Yes

No

If yes, list name of insurance company below

What type of coverage is it? (circle)

Group

Individual

Requested effective date: (Underwriting takes 2 to 4 weeks)

List current medications taken by each person and include dosage & how often it is taken & the condition treated & when started.

1

2

3

4

If taking Blood Pressure medication

list last 3 readings

5

6

7

If taking Cholesterol medication

list last reading

8

9

List any other recent health issues or surgeries

1

2

3

List any counseling in last 12 months

1

2

Fax to: 972-578-6687 or email: jeanette@bowmanbenefits.com