LIFE AND HEALTH QUOTE

PHONE: _____

NAME: _____ **D.O.B.** _____ **M/F** ____ **HT/WT** _____

SMOKER OR NONSMOKER

NAME: _____ **D.O.B.** _____ **M/F** ____ **HT/WT** _____

SMOKER OR NONSMOKER

NUMBER OF CHILDREN TO BE INSURED? _____

ADDRESS: _____

ANY PRE-EXISTING CONDITIONS ON ANYONE? YES OR NO
IF YES, WHAT KIND OF CONDITIONS AND ARE MEDICATIONS BEING TAKEN?

_____

_____

ANY INSURANCE NOW? YES OR NO IF YES, WITH WHO? _____

IS IT A GROUP OR INDIVIDUAL PLAN? _____

WHAT DEDUCTIBLE DO YOU CARRY? _____

DO YOU HAVE A CO-PAY FOR OFFICE VISITS OR A DRUG CARD FOR PRESCRIPTIONS? _____

IS THIS A TEMPORARY NEED (12 MONTHS OR LESS) OR LONG TERM FOR HEALTH COVERAGE? _____

*****DISABILITY INSURANCE ONLY*****

TYPE OF JOB? _____ **WHAT AMOUNT DO YOU NEED?** _____

*****LIFE INSURANCE ONLY*****

FACE AMOUNT NEEDED _____
($100,000 / 200,000)