HEALTH QUOTE

Date					Effective Date				
Applicant Information				Household Annual Income $					
	Name					Date of Birth			
	Address					City/State/Zip/County			
	Phone								
	M	F			Smoker	Yes	No		
	Dental	Yes	No		Vision	Yes	No		
Dependant Information									
	Name					Date of Birth			
	Address					City/State/Zip			
	Phone								
	M	F			Smoker	Yes	No		
Children	Yes	No							
	Name						Date of Birth		
	M	F		Smoker	Yes	No			
	Name						Date of Birth		
	M	F		Smoker	Yes	No			
	Name						Date of Birth		
	M	F		Smoker	Yes	No			
Currently Insured?			Name of Company						
If not currently insured please see page 2 - Do any of these qualifing events pertain?									
If so which									
Deductible	$	HMO	PPO	H.S.A					
Co-pay	100%	90%	80%	70%		BUDGET PREMIUM		$	

HEALTH QUOTE

Paid Dr Visits	$							