



INDIVIDUAL QUOTE REQUEST

*PLEASE PRINT CLEARLY AND RETURN VIA FAX OR U.S. MAIL

Broker: _____

1) Name: _____

2) Address: _____

County: _____ Zip Code: _____

Phone Number: _____ Requested Effective Date: _____

3) Who is to be covered:

Name	Sex	DOB	Height	Weight	Smoker (Y/N)

4) Medical Conditions: _____

5) Prescription Drugs: (Name/drug, amount taken/mg, how often) _____

6) Permanent (1 Year or more) - or - Temporary (1 to 12 Months) _____

7) Deductible Requested: _____

8) Extras (Maternity, Drug Cards, etc.) _____

9) How did you hear about us? _____

NOTES:

