Quote Request Form

Insured:

Phone (h) _____ (other) _____

Name _____ Height _____ Weight _____

DOB _____ Smoker _____

Address: _____

_____

Spouse

Name _____ Height _____ Weight _____

DOB _____ Smoker _____

Children

Name _____ Age _____ Sex _____

Name _____ Age _____ Sex _____

Name _____ Age _____ Sex _____

Questions:

- Where did you get our name? _____
- Current Carrier & monthly cost? _____
- Current benefits? _____

Health Questions:

1. Is anyone currently on any type of medication?

   Diagnosis _____ Onset _____ RX _____

   Prognosis _____ _____

   _____

   Diagnosis _____ Onset _____ RX _____

   Prognosis _____ _____

   _____

2. Has anyone ever been hospitalized? _____
3. Allergy shots or ear infections? _____
4. Do you want this to include maternity? _____