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benefit design associates, ltd.

INDIVIDUAL HEALTH QUOTE REQUEST FORM

INFORMATION **Date:** _____

Name: _____

Male ___ Female ___ Date of Birth: _____ Smoker ___ Non Smoker ___

Spouse's Name (if Applicable): _____

Male ___ Female ___ Date of Birth: _____ Smoker ___ Non Smoker ___

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____

Fax: _____

E-mail: _____

Preferred Method of Contact: _____

Child Age: _____ Gender: _____ Child Age: _____ Gender: _____

Child Age: _____ Gender: _____ Child Age: _____ Gender: _____

COVERAGE REQUESTED

PPO Deductibles: $500 ___ $1,000 ___ $1,500 ___ $2,500 ___ $5,000 ___

Health Savings Account Deductibles: $1,500 ___ $2,600 ___ $5,000 ___

HMO Plan: ___

MEDICAL HISTORY

Height: _____ Weight: _____ Spouse's Height: _____ Spouse's Weight: _____

Name	Medical Condition	Date Diagnosed	Treatment/Therapy (Medication, Chiropractor, Follow-up visits...)

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