



Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Height/Weight \_\_\_\_\_

Spouse: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Height/Weight \_\_\_\_\_

Dependent: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Dependent: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Dependent: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Dependent: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Phone #: \_\_\_\_\_ Zip Code \_\_\_\_\_ Email: \_\_\_\_\_

Does Anyone Smoke? \_\_\_\_\_ High Blood Pressure (Y/N) \_\_\_\_\_

Any Prescription Meds?  
\_\_\_\_\_  
\_\_\_\_\_

Any Hospital Stays (last 5 Yrs)  
\_\_\_\_\_  
\_\_\_\_\_

Any Pre- Existing -  
(cancer, stroke, Diabetes, Heart issues)  
\_\_\_\_\_  
\_\_\_\_\_

What current plan are you on and do you  
get a tax credit for your premiums?  
\_\_\_\_\_  
\_\_\_\_\_