



HEALTH INSURANCE QUOTE REQUEST SURVEY

PRINCIPAL PROPOSED INSURED: \_\_\_\_\_
OCCUPATION: \_\_\_\_\_ DATE: \_\_\_\_\_ AGENT NAME: \_\_\_\_\_
CITY: \_\_\_\_\_ COUNTY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_
REQUESTED EFFECTIVE DATE: \_\_\_\_\_

PLAN REQUESTED: PPO: 90/70 or 80/60 QUOTE HMO: [ ] yes [ ] no MAJOR MEDICAL/HOSPITALIZATION [ ] yes [ ] no

DEDUCTIBLE: [ ] \$250 [ ] \$500 [ ] \$1,000 [ ] \$1,500 [ ] \$2,000 OTHER \_\_\_\_\_

STOP LOSS: [ ] \$2,500 [ ] \$5,000 [ ] \$10,000 or indicate Max out of pocket: \$ \_\_\_\_\_

OPTIONAL BENEFITS

[ ] Supplemental accident: (\$300 or \$500 ER deductible) Maternity: [ ] yes [ ] no Rx card: [ ] yes [ ] no

Wellness: [ ] yes [ ] no Life Insurance Amount desired \$ \_\_\_\_\_

Dependent Life: [ ] yes [ ] no (Spouse - \$5,000 or \$2,500 / Child - \$2,500 or \$1,000)

Long term disability: [ ] yes [ ] no (If yes, indicate the elimination period): [ ] 90 or [ ] 180 days
Please indicate duration: [ ] 2yrs/RBD [ ] 5yrs/RBD [ ] to age 65/RBD

Short term disability: [ ] yes [ ] no (If yes, indicate if flat amount or by % of salary \_\_\_\_\_)
[ ] 13 weeks [ ] 26 weeks

Dental: [ ] yes [ ] no (If yes, indicate calendar year maximum) [ ] \$500 [ ] \$1,000 [ ] \$1,500

Orthodontia coverage: [ ] yes [ ] no (does the group have prior dental coverage? \_\_\_\_\_)

Current Carrier: \_\_\_\_\_ How long? \_\_\_\_\_ Current premium? \_\_\_\_\_

PLEASE NOTE THAT IN ORDER TO GET A PRE-SCREENED QUOTE FROM OUR OFFICE, YOU MUST PROVIDE COMPLETED APPLICATIONS for each proposed insured. THIS IS A "PROVISIONAL SURVEY" FOR A QUOTE REQUEST. Each carrier will require formal "application" for final offer.

Your email address: \_\_\_\_\_ (We are able to email most carriers quotes. We also try to send updates and important information by email.) Your fax number: \_\_\_\_\_

Should we: [ ] e-mail quotes to you [ ] fax quotes to you [ ] mail quotes to you

Authorized SIMG Agent Name: \_\_\_\_\_ Address: \_\_\_\_\_
Phone: \_\_\_\_\_



**Individual Health Census Information**

(Complete for each proposed insured)  
(Circle correct response if appropriate)  
**fax all pages to: (317) 841-5070**

1. Insured Name: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ M/F  
Occupation \_\_\_\_\_ (If retired or unemployed, previous occupation)  
Employed: full time/part time/retired/unemployed Relationship to Principal: \_\_\_\_\_
  
2. Has proposed insured been hospitalized within the past 5 years? (yes/no) If so, dates and Nature of Hospitalizations \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
3. Does proposed insured suffer from chronic condition(s) that requires regular medications? (yes/no) Describe. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
4. Does proposed insured suffer from chronic condition(s) that currently does not require regular medications? (yes/no) If so, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
5. List current prescribed medications, dosage and frequency: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
6. Current Smoker (yes/no) How many years? \_\_\_\_\_
  
7. Past Smoker (yes/no) How many years did proposed smoke? \_\_\_\_\_ When did proposed insured quit? \_\_\_\_\_
  
8. Has proposed insured been told he/she has: (High blood pressure/high cholesterol/high blood sugar)
  
9. Is proposed insured currently insured? (yes/no) Who is current insurer and what type of plan? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
10. If proposed insured is changing insurers, explain why? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
11. Other Comments or background you wish to state: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_