

QUOTE SHEET - *INDIVIDUAL MAJOR MEDICAL*

Fax to: 417-442-7622

e-mail to: service@insspecial.com

Applicant _____ Zip Code _____

| Needed Information | Applicant | | Spouse | | Child | Child | Child |
|--|------------|-------------|------------|------------|-------------|------------|------------|
| | DOB | Sex | DOB | Sex | DOB | DOB | DOB |
| 1. Occupation | _____ | | _____ | | Sex _____ | Sex _____ | Sex _____ |
| 2. Any Tobacco Use if no last used | Y | N | Y | N | Y | N | Y |
| 3. Height & Weight | H | W | H | W | H | W | H |
| 4. Hospitalized Last 3 Years? | Y | N | Y | N | Y | N | Y |
| 4-a. If YES - What was Reason? | _____ | | _____ | | _____ | _____ | _____ |
| 5. Treated for mental, alcohol or Drugs in last 5 years? | Y | N | Y | N | Y | N | Y |
| 6. Elevated Blood Pressure or Cholesterol Last 5 Years? | Y | N | Y | N | Y | N | Y |
| 7. Had a DWI/DUI in Last 5 Years? | Y | N | Y | N | Y | N | Y |
| 7-a. If YES - Now Many & When? | No. _____ | Date _____ | No. _____ | Date _____ | No. _____ | Date _____ | No. _____ |
| 8. Rx. Drugs in Last 6 Months? | Y | N | Y | N | Y | N | Y |
| 8-a. Name of Rx? | _____ | | _____ | | _____ | _____ | _____ |
| 8-b. Medical Condition? | _____ | | _____ | | _____ | _____ | _____ |
| 9. Any Other Medical Problems? | _____ | | _____ | | _____ | _____ | _____ |
| 10. Currently Pregnant or an Expectant Parent? If Yes- Coverage Not Available!! | Y | N | Y | N | Y | N | Y |
| 11. Current Medical Insurance? <i>Please Check One</i> | None _____ | Group _____ | Ind. _____ | None _____ | Group _____ | Ind. _____ | None _____ |

| | | |
|---|---|---|
| <p>PLAN DESIGN</p> <p>PPO Major Medical _____</p> <p>Health Savings Plan _____</p> | <p>DEDUCTIBLE (Please Circle)</p> <p>500 750 1,000 1,500 2,500 5,000 10,000 16,000 25,000</p> <p><u>Individual Plan</u> 1,000 1,750 2,600 5,000</p> <p><u>Family Plan</u> 2,000 3,500 5,200 10,000</p> | <p>Agents Name _____</p> <p>Phone No. _____</p> <p>Fax No. _____</p> <p>E-mail Add. _____</p> |
|---|---|---|

COVERAGE OPTIONS Please list Hospital of choice _____

Dr. Office Copay Y ___ N ___ City _____ State _____

Rx Card Y ___ N ___

Sup. Accident Y ___ N ___ \$500 \$1000 \$15,000 \$25,000

24 Hour Coverage Y ___ N ___

Dental Y ___ N ___ Plan 1 ___ Plan 2 ___ Plan 3 ___ Buy up option ___

Life Insurance - Client Y ___ N ___ Spouse Y ___ N ___ amount: \$10,000 \$25,000 \$50,000

INSURANCE SPECIALTIES, LLC
800-789-0182