Referred by: ____________________ Date: ____________________

Individual Health Proposal Questionnaire

Applicant:
Name: ____ DOB: ________________
Address: ____________________ ____
City: ________________ ST ________ ____________Ph (1) ________________ (2) ____________
Email: ____
Gender: __________Tobacco User? ________ Ever used? ______ If yes how long w/o use: __________
Family Size: __________Household Income:________________ Social Security #: ______________

Spouse:
Name: ____ DOB: ___________
Gender: __________Tobacco User? ________ Ever used? ______ If yes how long w/o use: ___________
Social Security #:____________________

Child (Children):
Name: ____ DOB: ________________
Gender: __________Tobacco User? ________ Ever used? ______ If yes how long w/o use: ___________
Social Security #: ____________________

Child (Children):
Name: ____ DOB: ________________
Gender: __________Tobacco User? ________ Ever used? ______ If yes how long w/o use: ___________
Social Security #: ____________________

Child (Children):
Name: ____ DOB: ________________
Gender: __________Tobacco User? ________ Ever used? ______ If yes how long w/o use: ___________
Social Security #: ____________________

Child (Children):
Name: ____ DOB: ________________
Gender: __________Tobacco User? ________ Ever used? ______ If yes how long w/o use: ___________
Social Security #: ____________________

Current or Prior Health Insurance Coverage: __ Company: ________________ Group or Individual

Preferred Coverage: TRAD, PPO, HMO, HSA. Deductible: $500, $1000, $2500, $ 3000, or _________