Referred by:	Date:
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## **Individual Health Proposal Questionnaire**

Applicant:			DOD.
Name:			DOB:
Address:	CTT -	DL (1)	(2)
Email:	51	Pn (1) _	(2)
Email:	Tobacco Usar?	Ever used?	If yes how long w/o use:
Family Size	Household Inc	Evel useu:	Social Security #:
ranny Size.	IIousenoiu inc	ome	Social Security #:
Spouse:			
Name:			DOB:
Gender:	Tobacco User?	Ever used?	If yes how long w/o use:
Social Security #:_		-	
Child (Children)			
Child (Children): Name:			DOB:
Gender:	Tobacco User?	Ever used?	If yes how long w/o use:
Social Security #: _			
Child (Children):			Don
Name:	T-1	10	DOB:
Gender:	l obacco User?	Ever used?	DOB:If yes how long w/o use:
social security #: _		_	
Child (Children):			
Vame:			DOB:
Gender:	Tobacco User?	Ever used?	DOB: If yes how long w/o use:
Social Security #: _			n jes non long mo user
Child (Children):			
Name:			DOB:
Gender:	Tobacco User?	Ever used?	DOB:If yes how long w/o use:
Social Security #: _			
Current or Prior H	ealth Insurance Cove	rage: Company:	Group or Individual
referred Coverage	e. IKAD, PPO, HMO	, ASA. Deductible: 5:	500, \$1000, \$2500, \$ 3000, or