Individual Insurance Intake Form

OFFICE USE ONLY

DATE: _____ AGENT NAME: _____ AGENT PHONE: _____

AGENT EMAIL: _____
REQUESTED QUOTE DATE (3 -5 business days from submittal date): _____

CLIENT INFORMATION

NAME:_____ SPOUSE (NAME): _____

EMAIL:_____ EMAIL:_____

HOME PHONE:_____ HOME:_____

WORK PHONE:_____ WORK:_____

ADDRESS:_____ CITY & STATE: _____

ZIP CODE:_____

DATE OF BIRTH _____/_____/_____ SPOUSE D.O.B. _____/_____/_____

MALE OR FEMALE (CIRCLE ONE) MALE OR FEMALE

SMOKER: YES OR NO (CIRCLE ONE) SMOKER: YES OR NO

IF CHILDREN NEED TO BE INCLUDED WITHIN QUOTE, PLEASE PROVIDE SAME INFORMATION AS ABOVE:

1. Name: _____ DOB: ____/____/_____ Smoker (Y / N): _____
2. Name: _____ DOB: ____/____/_____ Smoker (Y / N): _____
3. Name: _____ DOB: ____/____/_____ Smoker (Y / N): _____
4. Name: _____ DOB: ____/____/_____ Smoker (Y / N): _____
5. Name: _____ DOB: ____/____/_____ Smoker (Y / N): _____
6. Name: _____ DOB: ____/____/_____ Smoker (Y / N): _____

TOTAL LIVES: _____

THIS is a quote for:

HEALTH Insurance (circle one): YES or NO

If YES, does the client have a current plan? YES or NO
(If yes, attached current plan information)

If YES, what's the objective (circle): Better Benefits Cheaper Cost Both

Additional notes: _____

DENTAL Insurance (circle one): YES or NO

If YES, does the client have a current plan? YES or NO
(If yes, attached current plan information)

If YES, what's the objective (circle): Better Benefits Cheaper Cost Both

Additional notes: _____

REACH
HEALTH - DENTAL - VISION

THIS to quote for:

VISION Insurance (circle one): YES NO

If YES, does the client have a current plan? YES NO
(If yes, attach current plan information)

If YES, what's the objective (circle): Better Benefits Cheaper Cost Both

Additional notes: _____

Client Preferences:

PPO: NO YES ONLY

HMO/Select: NO YES ONLY

Specific doctors: NO YES (If Yes, provide list and details)

Specific hospitals: NO YES (If Yes, provide list and details)

Specific carriers to **INCLUDE:** _____

Specific carriers to EXCLUDE: _____

Chiropractic: NO YES

OOP: Minimum: $_____ Maximum: $_____

Rx (generic): Minimum: $_____ Maximum: $_____

Deductible: Minimum: $_____ Maximum: $_____

Monthly premium budget maximum: $_____

THIS to quote for (circle one):

Private/Direct Insurance **ACA (Covered CA)** **Short Term Policy**

Desired effective date (at least 30 days from submittal date): _____

Additional requests/concerns:

_____

_____

_____

_____

Preferred days and time ranges for a call (client availability):

Day 1 _____ Time range: _____ Day 2 _____ Time range: _____

I AUTHORIZE REACH INSURANCE SERVICES TO UTILIZE THE PROVIDED INFORMATION ABOVE TO QUOTE AND PROCESS INDIVIDUAL/FAMILY HEALTH, DENTAL, VISION & OTHER ASSOCIATED INSURANCE SERVICES.

CLIENT NAME (PRINT): _____ SIGNATURE: _____ DATE: _____