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Columbus, GA 31904
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E: info@michellecrawfordbenefits.com

Crawford Benefits

For Office Use Only
Date:
Entered:
Appointment Date:
Appointment Time:
Location:
Referred by:

CLIENT INFORMATION FORM 2022

All information contained in this questionnaire is strictly confidential
and used solely for seeking benefits to match the best plan for your needs.
*Consulting Agreement fee may be required.

Basic Information				
Last Name	First Name		M.I.	Birthday mm/dd/yyyy
Address	City	State	Zip	County
Home Phone: ( ) - -	Cell Phone: ( ) - -		Okay to Text? Yes ☐ No ☐	Gender Male ☐ Female ☐
Email Address:				
Annual Household Income	Tobacco Use? Yes ☐ No ☐	Eligible to receive Medicaid? Yes ☐ No ☐	Are you a U.S. citizen or legally present in the U.S.? Yes ☐ No☐	

Other Household Members						
Name	*Gender*	*Birthday*	*Relationship*	*Seeking Coverage?*	*Tobacco Use?*	*Is he/she on your tax return?*
	M☐ F☐	mm/dd/yyyy		Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
	M☐ F☐	mm/dd/yyyy		Yes☐ No☐	Yes☐ No☐	Yes ☐ No ☐
	M☐ F☐	mm/dd/yyyy		Yes☐ No☐	Yes☐ No☐	Yes ☐ No ☐
	M☐ F☐	mm/dd/yyyy		Yes☐ No☐	Yes☐ No☐	Yes☐ No ☐
	M☐ F☐	mm/dd/yyyy		Yes☐ No☐	Yes☐ No☐	Yes ☐ No ☐
	M☐ F☐	mm/dd/yyyy		Yes☐ No☐	Yes☐ No☐	Yes ☐ No ☐
	M☐ F☐	mm/dd/yyyy		Yes☐ No☐	Yes☐ No☐	Yes ☐ No ☐
	M☐ F☐	mm/dd/yyyy		Yes☐ No☐	Yes☐ No☐	Yes ☐ No ☐

Prior Healthcare Information	
Do you have prior health coverage? Yes ☐ No ☐	Healthcare policy type: Group (employer based) ☐ Individual ☐
Termination Date mm/dd/yyyy	What company is your prior health coverage carrier?

*Please flip this over and continue to page 2 of 2 of the client information form

Physician Information		
Doctor	*Type/Specialist*	*City Location*

Medications: Please list your prescribed medications. This is not required but will help to ensure adequate plan coverage.		
Name	*Strength*	*Frequency Taken*

Further Coverage Interest: Please select other coverages that you may be interested in.		
☐ Dental	☐ Cancer	☐ Hospital Indemnity
☐ Vision	☐ Critical Illness	☐ Accident
☐ Life	☐ Disability	☐ Not interested in others right now

Additional Notes/Comments

Do you have any referrals for us?

Name **Address** **Phone**