2223 Brookstone Centre Pkwy, Ste A
Columbus, GA 31904
Office: 706-257-5073 Fax: 706-568-9979
Email: info@michellecrawfordbenefits.com

Crawford Benefits

For Office Use Only

Date:
Entered:
Appointment Date:
Appointment Time:
Location:
Referred by:

CLIENT INFORMATION FORM 2023

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
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			Yes No	Yes No	Yes No
	M F			Yes No	Yes No	Yes No
	M F			Yes No	Yes No	Yes No
	M F			Yes No	Yes No	Yes No
	M F			Yes No	Yes No	Yes No
	M F			Yes No	Yes No	Yes No
	M F			Yes No	Yes No	Yes No
	M F			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:	What company is your prior health coverage carrier?

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

How did you hear about us?

_____

Do you have referrals for us?

Name: Phone:

Name: Phone:

Name: Phone:

Additional Notes/Comments