Insurance Networks of North Carolina
Customer Quote Request

Input Agent:_____ Referred By:_____ Year:_____

Services Needed: ☐Health Insurance ☐Life Insurance ☐Dental ☐Vision ☐Cancer ____ Accident

Other:_____

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APPLICANT INFORMATION

First Name: _____ MI: _____ Last Name: _____

US Citizen: ☐Yes ☐No If No, A#:_____ Certificate #: _____

DOB: _____ SS#: _____ County: _____

Telephone #: _____ Email: _____

Permanent Address: _____

City: _____ State: **NC** Zip: _____

Employer Name: _____ Phone#: _____

Income: ☐Yearly ☐Monthly ☐Weekly ___ Bi-Weekly $: _____

DEMOGRAPHICS

☐Male ☐Female	☐Married ☐Single	**Smoker:** ☐Yes ☐No

SPOUSE INFORMATION: (Fill in information only if Spouse needs insurance coverage)

First Name: _____ Last Name: _____

Social Security #: _____ DOB: _____ Income: _____

Employer Name: _____ Phone Number: _____

DEPENDENT INFORMATION: (Include Social Security Numbers only if children need insurance)

Number of Children: _____ Number in Household: _____ Household Income: _____

Name of Child/Children	Date of Birth	Gender	Social Security #
		☐ M ☐ F	
		☐ M ☐ F	
		☐ M ☐ F	
		☐ M ☐ F	