CONTACT NAME:_____

BUSINESS NAME:_____

ADDRESS:_____

CITY:_____**STATE:**_____ **ZIP:**_____ **BUSINESS PHONE:**_____

EMAIL:_____ **FAX:**_____

DATE OF BIRTH MALE:_____ **DATE OF BIRTH FEMALE:**_____

GENDER & DOB OF CHILDREN:_____, _____, _____

INSURED: Y / N CARRIER:_____ **DO YOU HAVE A CO-PAY FOR OV? YES OR NO?**

INDIVIDUAL OR GROUP? MONTHLY PREMIUM: _____ **DEDUCTIBLE:**_____

TOBACCO USER: Y / N Are there any Major Health Problems Currently? : Y / N

Are you taking any expense name brand drugs currently?_____

Is there a budget that you would like to keep your premium around? _____**/ Mo.**

You may actually qualify for some premium assistance based off of your income. What would you estimate your yearly household income will be this calendar year if you don't mind me asking?

_____

How often would you say you go to the doctor each year? A few times /several times /Once or Twice for a physical?

Would you be interested in having a Dental/Vision, or Life Insurance option along with this quote? Yes or No

In order to ensure you can go to the Dr. of your choice do you have a PCP preference right now?

_____

And, is there a hospital you would prefer to go to in the event of an accident or injury?_____

Contact Date: _____ **Contact Time:**_____

NOTES:_____

_____

_____

_____

_____

_____

_____

Hobby's/Interests/Favorite sports team, ect…

Follow Up Calls: 1 2 3 4 5 6 7 8 9 10 (X-out each time you call)