



Individual Health Insurance Quote

Benefit Marketing Group, Inc

Please complete the following information if you would like to obtain an individual health insurance quote. Please understand this is not an application for insurance. An application will be sent to you if from the Insurance Provider.

All information provided on this sheet is confidential and will be used solely for the purpose of developing a quote for you.

Last Name	First Name	Middle Name	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security #
Address		City	State	Zip

E-mail Address

Day Phone	Evening Phone	Fax	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated
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Applicant/Family Member to be enrolled

	Gender	Height (example 5'8")	Weight	Birthdate (00/00/00)
Applicant	<input type="checkbox"/> Male <input type="checkbox"/> Female		lbs.	
Spouse	<input type="checkbox"/> Male <input type="checkbox"/> Female		lbs.	
Child 1	<input type="checkbox"/> Male <input type="checkbox"/> Female		lbs.	
Child 2	<input type="checkbox"/> Male <input type="checkbox"/> Female		lbs.	
Child 3	<input type="checkbox"/> Male <input type="checkbox"/> Female		lbs.	
Child 4	<input type="checkbox"/> Male <input type="checkbox"/> Female		lbs.	

Any health problem that could affect premium?

Explain

Any special requests or remarks?

Please let us know the best time to call and discuss your quote.

Best Time to Contact You: Morning Afternoon Evening Anytime Specific Time _____

Affiliate ID _____ Affiliate Name _____

Fax to: 866-454-7922