BORSHOFF & ASSOCIATES

EMPLOYER / EMPLOYEE BENEFITS, SENIOR BENEFITS, INSURANCE & ANNUITIES

Individual Quote Sheet

Family Information

Name:		Age:		DOB:		Hght:		Wght:		Smoker:	
Spouse:		Age:		DOB:		Hght:		Wght:		Smoker:	
Child 1:		Age:		DOB:		Hght:		Wght:		Smoker:	
Child 2:		Age:		DOB:		Hght:		Wght:		Smoker:	
Child 3:		Age:		DOB:		Hght:		Wght:		Smoker:	
Child 4:		Age:		DOB:		Hght:		Wght:		Smoker:	

Address: _____ Phone: _____

_____ Cell: _____

City: _____ State: _____ Zip _____ Fax: _____

County: _____ Email: _____

Medical History

1. Within the last 5 years, have you:		
a. Consulted any doctor, counselor or therapist?	☐ Yes	☐ No
b. Been hospitalized or undergone any medical testing or treatment?	☐ Yes	☐ No
c. Been advised of the need for any future treatment or surgery?	☐ Yes	☐ No
2. Are you or any of your dependents currently pregnant?	☐ Yes	☐ No
3. Are you currently taking medication?	☐ Yes	☐ No
4. Have you filed any claims over $2,000 within the last 24 months?	☐ Yes	☐ No

For any questions answered "Yes", please provide complete details.

#	Person and Illness or Diagnosis	Dates		Type of Surgery or Treatment	Medication	Dose
		From	To			

Health Insurance Options

Deductible

☐ $500 ☐ $1000

☐ $2000 ☐ $2500

☐ $3500 ☐ $5000

☐ $7500 ☐ $10,000

☐ _____

Co-Insurance

☐ $2,500 ☐ $3,500 ☐ $12,500

☐ $5,000 ☐ $10,000 ☐ _____

Prescription

Copay: ____/____/____

Mail: ____/____/____

Insurance %

☐ HSA ☐ PPO ☐ HRA

☐ 50% ☐ 70% ☐ 100%

☐ 80% ☐ 90%

Dental: ☐

Vision: ☐

Dr. Office Copay: _____

1st Dollar: ☐

Current Health Insurance

Deductible: _____ **Premium:** _____

Insurance %

☐ HSA ☐ PPO ☐ HRA

☐ 50% ☐ 70% ☐ 80%

☐ 90% ☐ 100%

Prescription

Copay ____/____/____

Mail: ____/____/____

Dental: ☐

Vision: ☐

Dr. Office Copay: _____

1st Dollar: ☐

Life Insurance Options

☐ Term Life Insurance Face Amount: _____

☐ 10 years ☐ 20 years ☐ 30 years

☐ Universal Life

☐ Whole Life

Waiver of Premium

☐ Yes ☐ No

Approximate Monthly Budget Amount : _____

Reason for Coverage: _____