

Individual Health Insurance Quote Form

Effective Date: ___/___/_____

Today's Date: ___/___/_____

Resident State: _____ Address: _____

ZIP Code: _____ City: _____ County: _____

Phone# _____ Fax# _____

E-Mail: _____

Applicant Name: _____ Date of Birth: ___/___/_____

Male/Female Tobacco User: Yes/No Height: _____ Weight: _____

Spouse Name: _____ Date of Birth: ___/___/_____

Male/Female Tobacco User: Yes/No Height: _____ Weight: _____

Dependents Name and Date of Birth: _____

Has anyone ever been hospitalized? _____

Medications? (High Blood Pressure, Triglycerides, Cholesterol) _____

Additional Information: _____

Please complete the information above and fax it to 1-800-526-2107.

If you have any questions, please call us at 1-800-526-1485.

To view plans and prices immediately, you can go to our website at www.addgroup.com

Thank you for the opportunity to service your health insurance needs!