

American Health Source / Insurance Advisors, Inc. Health Insurance Quote Form

AHS Membership #: _____

Last Name	First Name	MI	Sex	Age	Date of Birth	Ht.	Wt.	Tobacco User Yes or No	
Address		City, State, Zip							
Home Phone		Work Phone			Email Address				
Spouse's Name (If Included)		Date of Birth		Ht.	Wt.	Tobacco User		Age	Sex
Childs Name (If Included)		Date of Birth				Age		Sex	
Childs Name (If Included)		Date of Birth				Age		Sex	
Childs Name (If Included)		Date of Birth				Age		Sex	
Childs Name (If Included)		Date of Birth				Age		Sex	

Current Insurance Company	Deductible	Premium	Doctor's Co-pay Yes ___ No ___	Co-Pay Drug Card Generic ___ Brand Name ___
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Anyone to be covered ever been declined for health insurance coverage, rated up or have a condition excluded? Yes ___ No ___

If so who, and what condition.	Date first diagnosed	Date of last treatment
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Anyone currently taking medication daily?	Name of Drug	Milligrams	Date treatment began?
Name			
Name			
Name			
Name			

Any family member currently pregnant?	Anyone ever diagnosed with: Cancer, Heart Problems, Kidney Failure, Diabetes or Uncontrolled Blood Pressure?	
	If so who?	Date of diagnosis

<u>Conventional Plan Deductibles:</u> 750 ___ 1500 ___ 2000 ___ 2500 ___ 5000 ___ 7500 ___ 10,000 ___ 15,000 ___	<u>HSA Health Savings Account Plan Deductibles:</u> Family 3200 ___ 4200 ___ 5200 ___ 7200 ___ 8200 ___ 9200 ___ 10200 ___ Individual 1600 ___ 2100 ___ 2600 ___ 3600 ___ 4100 ___ 4600 ___ 5100 ___
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Optional Benefits to be quoted: check to indicate

Prescription Drug Card ___ Disability Benefit ___ Dental ___ Additional Life or Critical Illness ___

Maternity Benefit ___ Additional Emergency Room Benefit ___

<p>PLEASE RETURN THIS FORM TO: Michael Sodini Insurance Services 420 Whitehall Road, #5 North Muskegon, MI 49445 Toll Free (866)744-5135 Fax (603)372-4964</p>	<p>Requested Effective Date: ___/___/___</p> <p>Email quote to: _____ @ _____</p> <p>Fax quote to: (____) _____</p>
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<p>Office Use Only Date Quoted: _____ Quoted by: _____</p>
