Univision Solutions

2775 Cruse Rd, Suite #202, Lawrenceville GA 30044

Ph: (770)817-7000 Fax: (770)817-7001

Health Insurance Quote Form

Please fill out the form below to request a Health Insurance Quote.

Applicant Information:

Applicant Name: _____

SSN: _____ Occupation: _____

Address: _____

City: _____ State: _____ Zip: _____

County: _____ Email ID: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Ref by: _____

Family Information:

Name	Relation	Date Of Birth (MM/DD/YYYY)	Gender (M/F)	Height/Weight	Smoker (Y/N)

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Check the box (es) below for anyone named in this pre-quote who has ever had treatment for any of the following conditions. Check all that apply. Please provide condition details on the next page.

- ☐ Alcohol
- ☐ Allergies/Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Kidney Problems
- ☐ Surgery in the past 5 years
- ☐ Surgery/hospitalization planned for in future
- ☐ Any health condition not mentioned
- ☐ Current Pregnancy
- ☐ Arthritis
- ☐ Counseling
- ☐ Heart Problems
- ☐ Psychological Disorders
- ☐ Hospitalization in past 5 years
- ☐ Claims over $2,000 in past 2 years

Condition Details:

Person	Condition/ Hospitalization/ Surgery	Treatment Date	Medications

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General Information:

Has anyone named in this pre-quote ever been declined and/or rated due to medical conditions?

Yes: ____ No: ___ If YES, who and by what Carrier? _____

Do you or anyone named in this pre-quote need maternity coverage? Yes: _____ No: _____

If you are nominating a Healthcare Provider/ Specialist, please complete the section below:

Name of Healthcare Provider/ Specialist: _____ Current Patient No Yes

Do you require any of the following optional coverage?

Dental Coverage: No Yes Vision Care Plan: No Yes

Existing/ Prior Coverage:

If you are applying for health coverage, please provide the status of current coverage or coverage within the past 24 months for each applicant. (Please provide a copy of Current/ Previous Medical Policy if applicable)

Do you or anyone applying for coverage have any major medical health insurance coverage **currently** in force? No Yes

• If **YES**, please supply the following for all applicants applying for coverage on the policy:

Name(s) of covered persons: _____

Medical Insurance Carrier Name: _____ Effective Date:_____

• If **NO**, please answer the following question:

Have you or anyone applying for coverage had major medical health insurance coverage within the **past** 24 months? No Yes

• If **YES**, please supply the following for all applicants applying for coverage on the policy:

Name(s) of covered persons: _____

Major Medical Insurance Carrier Name: _____

Effective Date: _____ Termination Date: _____

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Existing Dental/ Vision Coverage:

Does anyone applying for coverage currently have or had any group or individual Dental/ Vision coverage within the last 18 months? No Yes

• ***If YES, please supply the following for all applicants applying for coverage on the policy:***

Name(s): _____ Effective Date: _____

Insurance Carrier Name: _____ Termination Date: _____

Name(s): _____ Effective Date: _____

Insurance Carrier Name: _____ Termination Date: _____

Will the insurance coverage applied for be used to replace existing dental coverage? No Yes

Additional Information or Comments:

_____
_____
_____
_____
_____

ADDITIONAL INFORMATION:

Referred By: _____

We offer a full line of insurance products. Are you interested in talking to us about any of the following?

€ Homeowners Insurance

€ Life Insurance

€ Business Insurance

Applicant Name: _____ Signature:_____

Date: _____