Health Insurance Request Form

Name: **Address:**
Office #:
Home#: **C,S,Z:** , FL
Email: **Fax:**

1. Who is your current Health Ins Carrier
2. How long have they covered you?
3. Why do you want to leave them?
4. Do you Have a HMO/PPO or different Policy(HMO) (PPO)
5. What is your current premium? $ (Mo QTR)
6. Do you know your deductible? $
7. Do you want maternity? / Dental? (YES) (NO) / (YES) (NO)
8. Do you want Prescription / Vision? (YES) (NO) / (YES) (NO)
9. Do you want a co-pay for office visits or a deductible? (Co-Pay $______) (Deduct $______)
10. **Are there any doctors or hospitals that you need on the plan?** (YES) (NO)
    1.
    2.
    3.
    4.
11. What is your insurance budget? $__________ (Mo. / QTR)
12. Are you self employed (YES NO)
13. Are there any companies **YOU DO NOT WANT QUOTED**?
14. When do you expect to change plans?
15. Has anyone visited a Dr or Hospital in the last 5 years other then being sick or preventative care (Y N)*
16. Do you want Life / Disability Insurance (YES NO) Amount $ (Y N)
17. Any additional coverage's?

Name (Primary)	**DOB**	**Ht/Wt**	**S**	**Medications / Preexist***
Spouse (S)				
Children/Dependent		(C/D)		

S – Smoker?

* Additional Notes:

____
____
____
____

Requested: Date:

Marshall J. Kass 11217 NW 70th Court Parkland, FL 33076
(954) 340-2775 (954) 827-5774 Fax Mkass@romy.com www.marshallkass.com