

## Individual Health Information

**Agent:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Address (including zip code):** \_\_\_\_\_

**Height:** \_\_\_\_\_ **Weight** \_\_\_\_\_

**Tobacco: Yes** \_\_\_\_\_ **No** \_\_\_\_\_

**Pre-existing  
Conditions:** \_\_\_\_\_

**Medications:** \_\_\_\_\_

**Type of Plan and deductible  
desired:** \_\_\_\_\_

**Spouse Name:** \_\_\_\_\_

**Spouse DOB:** \_\_\_\_\_ **Tobacco: Yes** \_\_\_\_\_ **No** \_\_\_\_\_

**Spouse Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**Pre-existing  
Conditions:** \_\_\_\_\_

**Medications:** \_\_\_\_\_

**Children's Names and  
DOBs:** \_\_\_\_\_

**Email Address(for emailing  
quotes):** \_\_\_\_\_

**Notes:**