Individual Health Insurance Questionnaire

Date _____

Primary Contact

- **First Name**_____**Last Name**_____
- **Phone#**_____**Fax#**_____**Email**_____
- **Home Address**_____**City**_____**State**_____**ZIP** _____
- **Mailing Address (only if different)** _____

List all Persons to be Insured	Date of Birth mm/dd/yyyy	Gender	Height	Weight	Tobacco Use Yes	Tobacco Use No
_____	____/____/_____	☐ M ☐ F	_____	_____	_____	_____
_____	____/____/_____	☐ M ☐ F	_____	_____	_____	_____
_____	____/____/_____	☐ M ☐ F	_____	_____	_____	_____
_____	____/____/_____	☐ M ☐ F	_____	_____	_____	_____
_____	____/____/_____	☐ M ☐ F	_____	_____	_____	_____
_____	____/____/_____	☐ M ☐ F	_____	_____	_____	_____

Current Medical Insurance: ☐ None ☐ COBRA ☐ Group ☐ Individual

Name of Carrier_____ **Monthly Premium**_____

Why change desired? _____

Any other info?_____

Return this form to Carolyn Goodwin via fax at (972) 503-4241or email to cgoodwin@goodwinbenefits.com