

## Health Insurance Form

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

Address: \_\_\_\_\_

Phone: (     ) \_\_\_\_\_

Applicant: \_\_\_\_\_

Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: (     ) \_\_\_\_\_ DOB \_\_\_\_\_ Sex: \_\_\_\_\_ Smoker \_\_\_\_\_

1. Medical Problems, if any (for all applications)

\_\_\_\_\_

2. How long is insurance coverage needed? \_\_\_\_\_

3. If applying for family coverage: Number of Children \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ DOB \_\_\_\_\_ Smoker \_\_\_\_\_

\_\_\_ Health Insurance

• Short Term \_\_\_\_\_

• Permanent \_\_\_\_\_

\_\_\_ Life Insurance

\_\_\_ Disability Coverage

• Short Term \_\_\_\_\_

• Long Term \_\_\_\_\_

• Accident Only \_\_\_\_\_

\_\_\_ Dental Coverage

\_\_\_ Stand Alone Vision Plan

\_\_\_ Stand Alone Prescription Card

\_\_\_ Critical Illness Insurance

**Please complete and fax Health Insurance Form to: William P. Luke at  
513-829-7955**