Date: ____________________

Individual Quote Request Form

AGENT/ADVISOR INFORMATION

Name: ____ Phone: (____) ________-__________

Address: __________________________ City: __________________ State: _____ Zip Code: ___________

Fax: (____) ________-_________ E-mail: ____

APPLICANT INFORMATION *(All information is required to obtain a valid quote)*

Name: ____ Day Phone: (____) ________-__________

Home Address: ____

City: ___________________________ State: ______ Zip Code: ____________ County: _______________

QUOTE INFORMATION

Applicant… Gender: M F Date of Birth: ___/___/______ Smoker: Y N Maternity: Y N

Spouse… Gender: M F Date of Birth: ___/___/______ Smoker: Y N Maternity: Y N

Children…

Child's Name	Gender		Date of Birth	Full-time Student	
1. ____________________________	M	F	___/___/______	Yes	No
2. ____________________________	M	F	___/___/______	Yes	No
3. ____________________________	M	F	___/___/______	Yes	No
4. ____________________________	M	F	___/___/______	Yes	No
5. ____________________________	M	F	___/___/______	Yes	No

The information requested must be completed in order for your quote to be processed accurately. Please fax the completed form 847-332-0334 (Attn: Investment Centers Quoting) or e-mail to ica@flexiblebenefit.com.

For questions about completing this form, please call *Flex* at 866-472-5339.

NOTES: ____

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You will only receive quotes from carriers in which you are appointed through the Flex General Agency or where Flex is the writing agent

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Rev. 07/08

FLEX

For Broker/Dealer Use Only

Things to Know – Profiling Your Individual Clients

(For Advisor use only)

This tool will allow you to better understand the needs of your individual clients. By gathering this information, you will be able to establish a profile of your client and build a strategy for long-term success. This information is for your purposes only. Please do not send this information to Flex with your quote request form.

Client Name:____

Phone Number: ______________________________ Email: ______________________________

Current Carrier: ____

Current Effective Date: _________________________ Renewal Date: ________________________

Current Rates: ______________________________ Renewal Rates: _______________________

CURRENT BENEFITS:

Deductible: _________________________________ Office Visit Copay: ____________________

Family Deductible: ___________________________ Rx Drug Copay:________________________

Coinsurance: ________________________________ Emergency Room Copay: ________________

Out-of-Pocket Maximum: _______________________ Preventive Care Copay: _________________

Family Out-of-Pocket Maximum: _________________ Hospital Copay: _______________________

NOTES:

Known medical conditions: ____

____

____

Needs of client: ____

____

____

What to quote: ____

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ADDITIONAL INFO:

The following is a partial list of common medical conditions considered “declinable” by insurance carriers. If your client has any of these medical conditions, they likely will be declined for individual health insurance

- Alcoholism with less than 5 years recovery / drug addiction
- Diabetes Mellitus (Type 1 & 2)
- Down Syndrome
- Heart Disease
- Hepatitis C, D, E, or G
- HIV Positive / AIDS
- Hypertension (Uncontrolled, or less than 1 year controlled)
- Pregnancy
- Sleep Apnea

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