ANDERSON BENEFITS, INC.

INDIVIDUAL HEALTH PLAN PRE-QUALIFICATION QUESTIONNAIRE / UPDATE

How did you hear about our office? _____ Date: _____

Complete Census Information

Name: _____ **Spouse Name: _____**

DOB_____/_____/_____ Age _____ M/F **DOB_____/_____/_____ Age _____ M/F**

(Any family member use Tobacco? Other? Notes?)

Child Name: _____ DOB_____/_____/_____ Age_____ M/F
Child Name: _____ DOB_____/_____/_____ Age_____ M/F
Child Name: _____ DOB_____/_____/_____ Age_____ M/F
Child Name: _____ DOB_____/_____/_____ Age_____ M/F
Child Name: _____ DOB_____/_____/_____ Age_____ M/F
Child Name: _____ DOB_____/_____/_____ Age_____ M/F

Phone number(s) Cell: _____ Other_____
E-Mail(s)_____
Home Address:
Zip Code:

What's important about health insurance to you? _____

Current Insurance (circle): Group - Individual - PPO - HMO - HSA - On Exchange - Off Exchange - Medicare - Other

Current Plan Name:_____ Start ____/____/_____ End ____/____/_____Premium $_____

What type of benefits do you NOW have?_____

What type of benefits do you WANT?_____

When do you want the new coverage to start? _____

Important Hospitals or Doctors?_____

Do you want dental / vision or other benefits? _____

What will your household GROSS income be for next year your best guess? $_____

How many dependents do you claim on your taxes? _____

Notes: