

Quote Request Form

Section A: Quote Information

CIRCLE ONE: **HEALTH** **LIFE** **DISABILTY**

SALARY: _____ **OCCUPATION:** _____ **MATERNITY:** **Y** **N**

EFFECTIVE DATE: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

Phone (H): _____ **(W):** _____ **(C):** _____ **EMAIL:** _____

Section B: Applicant Information

FAMILY CODE	NAME (minimum last name, first initial)	BIRTH DATE	SEX	HEIGHT	WEIGHT	TOBACCO USE
Primary (APP)			M F			Y N
Spouse (SP)			M F			Y N
D1			M F			Y N
D2			M F			Y N
D3			M F			Y N
D4			M F			Y N

Section C: Medical History

FAMILY CODE	SPECIFIC DIAGNOSIS & TREATMENT DATES	CONDITION DATES		MEDICATION Name, Dosage, Frequency
		BEGIN	END	

Please send or fax to The Burns Insurance Agency at 419-471-1922