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	__________	_________	_____	_____
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___________________________________	____/____/_____	☐ M ☐ F	__________	_________	_____	_____

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

Name of Carrier____ **Monthly Premium**_______________________________

Why change desired? ____

Any other info?____

Medical History

Any surgery, major illness, hospitalization, broken bones in past 5 years? ☐ **Yes** ☐ **No**

Ever treated for asthma, heart condition, cancer, diabetes or other chronic condition? ☐ **Yes** ☐ **No**

Any routine or daily prescription medication(s) taken? ☐ **Yes** ☐ **No**

For each "yes" above, please provide a detailed explanation below.

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