

Associations Marketing Group, Inc.

Individual Request for Health Proposal

Member _____ of _____ an _____ Association? _____

Your _____ Name _____

Address _____ City _____
_____ State _____ Zip _____ County _____
_____ SSN # _____

Phone # _____ Phone Type _____ Other Phone _____ Phone Type _____
Fax _____ Email _____ Address _____

Current Medical Insurance Company _____ Renewal Date _____

Deductible Amount _____ Co-Insurance _____ Co-Pay? _____

Your Current Premium is \$ _____ Paid (Circle One) Monthly Quarterly Semi-Annually Annually

Your Current Health Plan is (Circle One) No Plan Single Plus Spouse Plus Children Family

Your Date of Birth _____ Sex M _____ F _____ Smoke? Y _____ N _____ Height _____ Weight _____

Spouses Date of Birth _____ Sex M _____ F _____ Smoke? Y _____ N _____ Height _____ Weight _____

Number of Dependents _____ Sex & Age of Dependents _____

Need maternity coverage? Y _____ N _____

Please list below the Doctors & Hospitals you prefer to use _____

- No Yes Is anyone currently pregnant?
 No Yes Any medical claims over \$2,500.00 or anyone hospitalized in the past 12 months?
 No Yes Is anyone currently taking medications?
 No Yes Anyone with a history of treatment for Diabetes, Heart, Stroke, Cancer, or Disability?

If yes is checked on any of the items above, please explain!

Optional Benefits

Dental

Life Insurance

Disability Insurance

Vision

Please circle any optional benefit you would like us to get quotes for

1112 Maple Street West Des Moines, IA 50265

Local - 515 270-8178 Toll Free - 800 798-6772 Fax - 515 270-0398 Email - mail@amgi-dsm.com Web – www.amgi-dsm.com

The information you supply on this page will be not be shared or sold, and will only be used to help you find health benefits.
Please fill out this form as completely as you can, so we can provide you the fastest most efficient service possible.