

Individual Health / Life / Disability Data Sheet

Client Name _____

Address _____

City/State/Zip _____

	First Name	DOB	Age	Height	Weight	Smoker	Relationship	Known Condition
1							Insured	
2								
3								
4								
5								
6								

If Yes to Known Condition please reference the client # and describe: _____

Health Insurance Plan Options

Current Carrier _____ Expiration Date _____

Requested Effective Date _____

Requested Deductible: \$500 \$750 \$1,000 \$1,500 \$2,000 \$2,500 \$5,000 \$7,500 \$10,000

Life Insurance Plan Options

Plan Type: Term Universal Whole Plan Term(in years): 10 15 20 30

Policy Amount: \$ _____ Current Life Insurance Carrier _____

Occupation: _____

Disability Insurance Plan Options

Monthly Benefit Amount \$ _____ Monthly Salary \$ _____

Occupation: _____

Current Disability Policy Y N

If yes- Is this going to Replace or be in Addition to? _____

Current Benefit amount \$ _____ or _____%