

Individual Quote Request

Southeastern Agency

Date: _____ Requested Start Date of Insurance: _____

Phone: (____) _____ Fax: (____) _____

APPLICANT:

Name: _____ DOB: _____ Sex: _____ Ht: _____ Wt: _____

Tobacco Use (circle one): Y/N Occupation: _____

County: _____ State: _____ Zip Code: _____

How would you like to be contacted (email or phone): _____

SPOUSE:

DOB: _____ Sex: _____ Ht: _____ Wt: _____

Tobacco Use (circle) Y/N: Occupation: _____

CHILDREN:

of Children: _____ Sex and age of each child _____

MEDICATIONS AND MEDICAL CONDITIONS FOR EACH PERSON:

Patient name: Condition: Medication/Dosage: Other Treatment:

Is insured or dependents pregnant or an expectant parent? Yes _____ No _____

Has insured or dependents been hospitalized, had surgery, or contemplating surgery?

Yes _____ No _____ If yes, please explain:

Please fax completed form to 740-593-7388 or email receptionist@seagency.com