

GROUP HEALTH QUESTIONNAIRE

Name of Business: _____ Phone Number: _____

Address: _____ Fax Number: _____

City: _____ State: _____ Zip: _____ Email Address: _____

Nature of Business: _____ Contact Person: _____

Employees to be covered (attach additional list if needed):

Name	Date of Birth	Sex	Coverage* Code*	DOB of spouse (if applying)	Number of Children (if applying)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

*coverage code: EO- Emp. Only EC- Emp. & child(ren) ES- Emp. & spouse EF- Emp. & family

Current Dental Coverage? Yes ___ No ___ Current Group Life Insurance? Yes ___ No ___ Amount: _____

Is the employee paying for any portion of the health premium? Yes ___ No ___ What portion? _____

Current Carrier: _____ Current Deductible: _____

Expiration Date: _____ Current monthly premium: _____

Disclaimer:
This form is for cost estimate purposes only.
A quote can be provided and coverage can
be bound only after an underwriter approves
a fully completed application.

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