

INDIVIDUAL HEALTH QUESTIONNAIRE

Name: _____ Phone Number: _____
 Home Address: _____ Fax Number: _____
 City: _____ State: _____ Zip: _____ Email Address: _____

Persons to be covered:

Name	Sex	Date of Birth	Height	Weight	Tobacco User
Applicant					
Spouse					
Dependent					
Dependent					
Dependent					
Dependent					

If there are any medical conditions, please list them here and advise to whom they apply. Please include any medications and dosage amount that is currently being taken.

Do you currently have health insurance? No Yes
 If "Yes", Please complete the following:

Current Carrier: _____ Expiration Date: _____
 Deductible: _____ Current Deductible: _____

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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