

**J.B. Gross Insurance**

*Metro- (817)613-1098*

*Fax- (866)613-1360*

**Insurance Suspect Sheet for Individuals**

Contact Person: \_\_\_\_\_

Date Submitted: \_\_\_/\_\_\_/\_\_\_ Referred By: \_\_\_\_\_ Effective Date: \_\_\_/\_\_\_/\_\_\_

(1) Prospect's Name: \_\_\_\_\_ Ht: \_\_\_' / \_\_\_" Wt: \_\_\_\_\_ Gender: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Occupation: \_\_\_\_\_ Tobacco User: \_\_\_\_\_

(2) Spouse: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Ht: \_\_\_' / \_\_\_" Wt: \_\_\_\_\_

Spouse's Occupation: \_\_\_\_\_ Tobacco User: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_ Work Phone: \_\_\_\_\_ ( 1 / 2 )

Email Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ ( 1 / 2 )

**Dependent Information**

(3) Child: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Gender: \_\_\_\_\_ Ht: \_\_\_' / \_\_\_" Wt: \_\_\_\_\_ Tobacco: \_\_\_\_\_

(4) Child: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Gender: \_\_\_\_\_ Ht: \_\_\_' / \_\_\_" Wt: \_\_\_\_\_ Tobacco: \_\_\_\_\_

(5) Child: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Gender: \_\_\_\_\_ Ht: \_\_\_' / \_\_\_" Wt: \_\_\_\_\_ Tobacco: \_\_\_\_\_

**Check the type(s) of coverage to be quoted**

PPO: \_\_\_\_\_ HSA: \_\_\_\_\_ Indemnity: \_\_\_\_\_ Other: \_\_\_\_\_

**Carriers to Quote**

Aetna: \_\_\_\_\_ BCBS: \_\_\_\_\_ Fortis: \_\_\_\_\_ UniCare: \_\_\_\_\_ Other: \_\_\_\_\_

**Deductibles Requested**

\_\_\_\_\_ \$250 \_\_\_\_\_ \$500 \_\_\_\_\_ \$750 \_\_\_\_\_ \$1000 \_\_\_\_\_ \$1500 \_\_\_\_\_ \$2500 \_\_\_\_\_ \$5000

Co-pay Requested: Y / N

Drug Card: Y / N

Dental: Y / N

**Any Pre-existing Conditions**

Cholesterol: \_\_\_\_\_ Diabetes: \_\_\_\_\_ Hypertension (High Blood Pressure) \_\_\_\_\_ Cancer: \_\_\_\_\_

Current Coverage: \_\_\_\_\_

Additional Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_