(817) 613-1098

J.B. Gross Insurance Agency LLC

FAX (817) 613-1360

Individual Insurance Information Sheet

Date Submitted:_____ Information taken by:_____ Referred by:_____

Effective Date:_____ (1) Prospect's Name:_____ Contact Person:_____

Gender: Male ☐ / Female ☐ DOB:_____ Tobacco: YES ☐ / NO ☐ Occupation:_____

Address:_____ City:_____ Zip:_____ County:_____

E-mail Address:_____ Single ☐ Married ☐ Children(#):_____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ (1☐ 2☐) Cell Phone: (_____) _____-_____ (1☐ 2☐)

Dependent Information

(2) Spouse:_____ M☐ F☐ DOB:_____ Tobacco: YES ☐ / NO☐ Occupation:_____

(3) Child:_____ M☐ F☐ DOB:_____ Tobacco: YES ☐ / NO ☐

(4) Child:_____ M☐ F☐ DOB:_____ Tobacco: YES ☐ / NO ☐

(5) Child:_____ M☐ F☐ DOB:_____ Tobacco: YES ☐ / NO ☐

(6) Child:_____ M☐ F☐ DOB:_____ Tobacco: YES ☐ / NO☐

Check the type(s) of coverage to be quoted

HSA ☐ HMO ☐ Dental ☐ Life ☐ Disability ☐ STM ☐ Supplemental ☐

Co-pay Requested

YES ☐ / NO ☐

Deductible Requested

$0-$2000 ☐ $3150-$5000 ☐ $6000-$7900 ☐

Drug Card

YES ☐ / NO ☐

Current Coverage: YES ☐ / NO ☐

-If YES: Until when? _____ Carrier's Name:_____ Current Premium: $_____

-If NO: Is Cobra available to you? YES ☐ / NO ☐ How long have you been without coverage? _____

Physician/Network Check: *List your current doctor(s)* using column (#) to correspond to the (1) Applicant (2) Spouse (3) Child (4) Child (5) Child (6) Child*

PHYSICIAN'S FULL NAME	#	PROVIDER TYPE (GP, OBGYN, etc)	PHONE NUMBER	CITY & ZIP CODE

Medications List: List ALL PRESCRIPTIONS, include TYPE [Capsules/Tablets/Liquid/Etc.] ,and DOSAGE (NO OVER THE COUNTER OR NON-PRESCRIPTIONS)

**Print additional sheets if needed for provider or medication information*

_____ _____

Prospect's Signature Date