

Health Plus Consulting Services, Inc.

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REQUEST FOR INDIVIDUAL QUOTE

Name _____ Requested Effective Date _____

Phone: _____ Cell: _____ Fax: _____

Address _____ City _____ State ___ Zip _____

Age _____ Weight _____ Current Carrier _____

Dependants Name/Age/Weight (If any) _____

Current Benefits _____

1. Did you or your dependents incur medical expenses of \$5,000 or more during the last 12-month period? YES _____ NO _____

2. Please circle the type of plan you are interested? (circle one) PPO HMO Unsure

3. Do you or your dependants currently have serious health problems? (For example, but not limited to: cancer, heart trouble, neuromuscular disorder, AIDS, kidney trouble, paralysis or diabetes)
YES _____ NO _____

4. Is there an active maternity case? YES _____ NO _____

5. Are you or your dependants on disability or on waiver of premium status? YES ___ NO ___

6. If the answer to any of the above is YES, please give details including:

NAME: _____

Health Conditions (Dates)/Type of Treatment and Charges: _____

Name of Individual

Signature of Individual

Date