Agent Name: __________

Specialist: __________

Date Needed: __________

SeaGate Benefits Administrators, Inc.

REQUEST FOR PROPOSAL – INDIVIDUALS & FAMILIES

NAME OF INDIVIDUAL:____

HOME ADDRESS:____

CITY: ____________________ **STATE:**____________________ **ZIP:**_______________

COUNTY:____________________ **DAYTIME PHONE NUMBER:**____________________

DATE OF BIRTH:_____________ **SEX:** M or F **SMOKER:** Y or N **HT:**_______ **WT:**_________

NAME OF SPOUSE:____

DATE OF BIRTH:_____________ **SEX:** M or F **SMOKER:** Y or N **HT:**_______ **WT:**_________

CHILD #1:________________ **DOB:**___________ **SEX:** M or F **HT:**________ **WT:**________

CHILD #2:________________ **DOB:**___________ **SEX:** M or F **HT:**________ **WT:**________

CHILD #3:________________ **DOB:**___________ **SEX:** M or F **HT:**________ **WT:**________

CHILD #4:________________ **DOB:**___________ **SEX:** M or F **HT:**________ **WT:**________

WHAT KIND OF INDIVIDUAL PLAN ARE YOU LOOKING FOR?

MEDICAL:______ **HSA:**______ **DENTAL:**______ **VISION:**______ **LIFE:**______

MATERNITY RIDER:_______ **OFFICE VISIT COPAY:**_______ **PRESCRIPTION RIDER:**_______

DEDUCTIBLE'S: $500:_____ **$1,000:**_____ **$1,500:**_____ **$2,500:**_____ **OTHER:**________

WHAT EFFECTIVE DATE ARE YOU LOOKING FOR?________________________________

DO YOU CURRENTLY HAVE HEALTH INSURANCE?_________ **WITH WHOM?**_________________

ARE YOU SELF EMPLOYED?

If you would like a "ONE PERSON GROUP PRESCREEN" Please complete below to receive FormFire, the electronic application system for group health insurance. We CANNOT quote without Tax ID!

Name of Business: ________________________________ **Employer Tax ID#**________________

Address:____

____

Type of Business:________________________________ **or SIC Code:**________________________

E-mail Address:____

This is for Quoting Purposes Only. Please complete this form & the attached Medical History Questionnaire.
Return to your Agent or SeaGate Benefits Administrators Inc. at fax #419.517.7406 or call 419.517.7079 ext. 220.

6711 Monroe Street, Building V, Sylvania, OH 43560
Phone: 419.517.7079 Fax: 419.517.7406

MEDICAL ELIGIBILITY

Has **ANY PERSON TO BE COVERED** within the past ten years been treated for, diagnosed as having, hospitalized, had surgery, been recommended for future surgery, diagnostic testing or medical treatment or thought you should seek medical advise for any of the following conditions? Each Condition must be checked(√) yes or No

CONDITION	yes	no
1. Abnormal Pap Smears	__	__
2. AIDS, ARC, or HIV	__	__
3. Allergies	__	__
4. Alzheimer's Disease	__	__
5. Aneurysm	__	__
6. Anorexia/Bulimia	__	__
7. Arthritis (TYPE________)	__	__
8. Asthma	__	__
9. Back Sprains/Strains	__	__
10. Bronchitis	__	__
11. Bursitis	__	__
12. Cancer (TYPE__________)	__	__
13. Cardiomyopathy	__	__
14. Carotid Artery Disease	__	__
15. Carpel Tunnel Syndrome	__	__
16. Cataracts	__	__
17. Cerebral Palsy	__	__
18. Cholesterol (High)	__	__
19. COPD or Emphysema	__	__
20 Cirrhosis of the Liver	__	__
21. Colitis (Including Ulcerative)	__	__
22. Colon Polyps	__	__
23. Congenital Disorders	__	__
24. Congestive Heart Failure	__	__
25. Coronary Artery Disease (Including Angina and Angioplasty)	__	__
26. Coronary Insufficiency	__	__
27. Crohns Disease	__	__
28. Cystic Fibrosis	__	__
29. Cystitis (Chronic or interstitial)	__	__
30. Cysts, Tumors or Growths	__	__
31. Diabetes/Blood Sugar Disorder	__	__
Last 3 Blood Sugars & Dates:		
1) ____________________		
2) ____________________		
3) ____________________		

CONDITION	yes	no
32. Diverticulitis/Civerticulosis	___	__
33. Down's Syndrome	___	__
34. Drug/Alcohol Abuse (including DUI's)	___	__
35. Endometriosis	___	__
36. Fibrocystic Breast Disease	___	__
37. Fibromyalgia	___	__
38. Gallbladder Disease	___	__
39. Gastric Reflux (GERD)	___	__
40. Gastric Bypass/Banding	___	__
41. Gout	___	__
42. Graves Disease	___	__
43. Growth Deficiency	___	__
44. Guillian Barr Syndrome	___	__
45. Heart Attack	___	__
46. Heart Bypass Grafting	___	__
47. Heart Murmur	___	__
48. Heart Palpitation/Arthythmia	___	__
49. Heart Valve Disorders	___	__
50. Hemorrhoids	___	__
51. Hemophilia	___	__
52. Hydrocephalus/Shunt	___	__
53. Hypertension (High Blood Pressure)	___	__
Last 3 Pressures & Dates:		
1) _____________________		
2) _____________________		
3) _____________________		
54. Ileostomy/Colostomy	___	__
55. Infertility	___	__
56. Irritable Bowel Syndrome	___	__
57. Joint Replacement	___	__
58. Kidney Failure	___	__
59. Kidney Stones	___	__
60. Liver Disorders/Hepatitis	___	__
61. Lou Gehrig's Disease (ALS)	___	__
62. Meningitis	___	__
63. Menstrual Disorders (including Abnormal Cycles/Uterine Bleeding)	___	__

CONDITION	yes	no
64. Mental Health Disorders (including Depression, anxiety, ADD & ADHD and continuing)	__	__
65. Migraines	__	__
66. Multiple Sclerosis	__	__
67. Muscular Dystrophy	__	__
68. Organ Transplant/Failure	__	__
69. Osteoporosis	__	__
70. Otitis Media (ear infection)	__	__
71. Ovarian Cyst/Polycystic	__	__
72. Pacemaker Implantation	__	__
73. Pancreatitis	__	__
74. Paralysis	__	__
75. Parkinson's Disease	__	__
76. Peptic/Gastric Ulcer	__	__
77. Peripheral Vascular Disease	__	__
78. Phlebitis/Blood Colt	__	__
79. Polycystic Kidney Disease	__	__
80. Prostate Disorders	__	__
81. Schizophrenia/Bipolar	__	__
82. Scleroderma	__	__
83. Seizure Disorder/Epilepsy	__	__
84. Sexually Transmitted Disease	__	__
85. Skin Conditions (includes Acne, Psoriasis, Rosacea, Nail Fungus)	__	__
86. Sleep Apnea	__	__
87. Spina Bifida Cystica/Occulta	__	__
88. Spinal Disorders/Disc Disease		
89. Stroke	__	__
90. Suicide Attempts/Psych Admits	__	__
91. Systemic Lupus	__	__
92. Tendonitis	__	__
93. Thyroid Disorder	__	__
94 TMJ	__	__
95. Tonsilillitis	__	__
96. Transient Ischemic Attacks (TIA)	__	__
97. Varicose Veins	__	__
98. Other Condition(s) not listed	__	__

In the past ten years, has **ANY PERSON TO BE COVERED** been treated, diagnosed, undergone surgery, been confined to a hospital or treated in an emergency room, or consulted a physician for any illness, injury, medical abnormality or mental or emotional condition not stated in questions 1 through 98? ☐ YES ☐ NO (If YES please explain below)

If any question A through F or conditions 1 through 98 are checked "YES", please explain below, (use additional paper, if necessary). Indicate all details of the injury, ailment or condition. Include items such as specific location of condition (example: right knee), diagnosis, type of treatment and hospitalization.

Question/Condition	**Patient's Name**	**Details of Injury, Aliment or Condition**	**Start & End Dates(s) of Treatment(s) Medications Dosage**	**Physician**

This is for quoting purposes only, not an application for health insurance.