CONFIDENTIAL Personal Health Insurance Information Form * IMPORTIANT *** If applying thru an employer either fax directly to A Insurance Shoppe or put in a sealed envelope and give to your employer.**

Name ______________________________ **Spouse** ______________________

Address ______________________________ **County** __________ **Zip** ________

City __________ **State**__ **Phone** __________ **Fax** __________ **E-mail** ______________

Primary age & height/weight ________________ **Spouse age & height/weight** ________________

Child name age & height/weight ______________________________

Child name age & height/weight ______________________________

Child name age & height/weight ______________________________

Child name age & height/weight ______________________________

Occupation(s) ______________________________

Current or most recent (include termination date) health insurance & premiums. Was it Individual ☐ or Group ☐

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A condition you consider nothing, may be important to the insurance company, the more information we have, the better we can "Shoppe" for you. Have you or any immediate member of your family who are Appling been diagnosed or treated, including medications, (or need treatment) for any of the following conditions within the past 10 years?

Please mark each question Yes or No, **IMPORTANT provide information below to any question marked "Yes**

1. Cancer or tumor? ☐ Yes / No ☐
2. Diabetes? ☐ Yes / No ☐
3. Alcohol/illicit drug use or abuse? ☐ Yes / No ☐
4.Liver disease/Cirrhosis/Hepatitis? ☐ Yes / No ☐
5.Been declined/ridered for health insurance? ☐Yes /No ☐
6. Gall bladder, liver, stomach or intestines? ☐ Yes / No ☐
7. Immune system (AIDS, ARC)? ☐ Yes / No ☐
8. Psychological/depression conditions? ☐ Yes / No ☐
9. Heart conditions operations/hypertension/stroke? ☐ Yes / No ☐
10.Bones/joints/muscles/arthritis? ☐ Yes / No ☐
11.Kidney/urinary tract/bladder (stones, infection)? ☐ Yes / No ☐
12. Neurological (headache, seizures)? ☐ Yes / No ☐
13.Eye, ear, nose and throat condition? ☐ Yes / No ☐
14. Reproductive disorders or STD (Sexually Transmitted Disease? ☐ Yes / No ☐
15. Does any applicant have any ongoing disabilities or receiving disability benefits? ☐ Yes / No ☐
16. Is any applicant currently pregnant or expecting to be a parent? ☐ Yes / No ☐
17. Has anyone applying for coverage been a patient in a hospital, outpatient surgi-center, sanitarium, or other medical facility as an inpatient ☐ Yes / No ☐
18. Have any claims over $2,500 been billed (or incurred) in the last 24 months? ☐ Yes / No ☐
19. Asthma, allergies, lung or respiratory conditions? ☐ Yes / No ☐
20. Abnormal test results? ☐ Yes / No ☐
20. Does any applicant have any signs, symptoms, conditions, or concerns for which medical attention has **not** yet been sought or ANY other conditions not listed above? ☐ Yes / No ☐
22. Please list any prescription medications taken in the last 12 months? Anyone Smoke? How long? ☐ Yes / No ☐

Name	#	Condition, symptoms, diagnosis	Types of treatment test, surgery etc.	Degree of recovery	Doctor/Provider Name/address
Name					
Dates, from / to					
Name					
Dates, from / to					
Name					
Dates, from / to					
Name					
Dates, from / to					
Name					
Dates, from / to					
Name					
Dates, from / to					

I/we authorize Shoppe Insurance, and their authorized representatives to use medical information obtained in order to evaluate insurability and premiums of the proposed persons listed above. **Primary** ________________**Spouse** ________________

A INSURANCE Shoppe www.123411.com PO Box 12907 Tucson, AZ 85732-2907 FAX 520-318-9400 (1-888-301-4329) PHONE 520-318-4800 (1-800-763-7890) We "Shoppe for You! ©2006 A Insurance Shoppe