TALUS
BROKERAGE SERVICES

Generic Individual Pre-Screen / Quote Form

BROKER NAME: _____

SECTION A - COVERAGE INFORMATION

WHICH CARRIERS ARE YOU INTERESTED IN QUOTING?

PRODUCT SELECTION	Aetna	MMO Farm Bureau	MMO	Assurant
Medical (List Deductible)				
Dental/Vision/Life (circle)	Dental	Dental Life	Dental Vision Life	Dental Vision Life

PRODUCT TYPE (SELECT ONE): ☐ Standard ☐ HSA Plan

SECTION B - APPLICANT INFORMATION

First Name , M.I.	Last Name	Social Security Number	
City	State	Zip	County
Height (Ft./In.) / Weight	Sex: M F	Age	Date of Birth (MM/DD/YYYY) / /

SECTION C - SPOUSE INFORMATION

First Name , M.I.	Last Name	Social Security Number	
Height (Ft./In.) / Weight	Sex: M F	Age	Date of Birth (MM/DD/YYYY) / /

SECTION D – CHILD DEPENDENTS TO BE COVERED INFORMATION (ALL FIELDS REQUIRED. ATTACH A SEPARATE SHEET IF NECESSARY.)

Last Name, First Name	Sex M/F	Relationship	Birthdate	Height	Weight	F/T Student?
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

Tobacco Use: Have you or anyone on this application used tobacco in the last 12 months? ☐ Yes ☐ No

If "YES", please specify who:

OTHER COVERAGE INFORMATION

Has anyone on this application been covered with health benefits within the past 2 years? ☐ Yes ☐ No

List dates covered:

** If no medical information is disclosed, street rates will be provided; and, application will not be sent to an underwriter.
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[Form rev.10/1806]

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SECTION E – HEALTH HISTORY

Have you or any family member consulted with or been examined or treated by any health care professional for any illness, injury, or health condition in any of the categories listed below? If "YES", please check the box that most appropriately describes the problem and explain fully below. PLEASE NOTE THAT, IF YOU LEAVE OUT OR MISREPRESENT INFORMATION, RATES MAY BE INACCURATE.

1A Cancer/Tumor ☐ Yes ☐ No	☐ Breast ☐Colon ☐ Leukemia ☐ Lymphoma ☐ Liver ☐ Lung ☐ Melanoma ☐ Other _____
1B Heart/Circulatory ☐ Yes ☐ No	☐ Aneurysm ☐Bypass ☐ Angioplasty/Stent ☐ Congestive Heart Failure ☐ Elevated Cholesterol/Triglycerides ☐ Heart Disease ☐High Blood Pressure ☐ Phlebitis ☐ Skin Ulcer ☐Stroke ☐Varicose Veins ☐Other
1C Reproductive ☐ Yes ☐ No	☐ Current Pregnancy (due date _____) ☐ Multiple Expected (#_____) ☐ Pregnancy Conditions (Present or Past) ☐ Breast Disorders ☐ Endometriosis ☐ Infertility ☐ Other _____
1D Intestinal/Endocrine ☐ Yes ☐ No	☐ Chronic Pancreatitis ☐ Colon Disorder ☐ Crohn's ☐ Ulcerative Colitis ☐ Diabetes ☐ Gallbladder ☐ Hepatitis B/C ☐ Hiatal Hernia/Reflux ☐ Liver Disorder ☐ Ulcer ☐ Growth Hormones ☐ Other _____
1E Brain/Nervous ☐ Yes ☐ No	☐ Alzheimer's Disease ☐ Cerebral Palsy ☐ Migraines ☐ Multiple Sclerosis ☐ Paralysis ☐ Seizures/Epilepsy ☐ Parkinson's Disease ☐ Other _____
1F Immune ☐ Yes ☐ No	☐ AIDS ☐ HIV+ ☐ Lupus ☐ Other _____
1G Lung/Respiratory ☐ Yes ☐ No	☐ Allergies ☐ Asthma ☐ Cystic Fibrosis ☐ Emphysema ☐ Chronic Bronchitis ☐ Pneumonia ☐ Tuberculosis ☐ Sleep Apnea ☐ Other _____
1H Eyes/Ears/Nose/Throat ☐ Yes ☐ No	☐ Acoustic Neuroma ☐ Cataracts ☐ Chronic Ear Infections ☐ Chronic Sinusitis ☐ Cleft Lip/Palate ☐ Deviated Septum ☐ Glaucoma ☐ Retinopathy ☐ Other _____
1I Urinary/Kidney ☐ Yes ☐ No	☐ Kidney Stones ☐ Neurogenic Bladder ☐ Polycystic Kidney Disease ☐ Prostate Disorder ☐ Renal Failure ☐ Other _____
1J Bones/Muscles ☐ Yes ☐ No	☐ Arthritis (Rheumatoid or Osteo) ☐ Bulging/Herniated Disc ☐ Joint Injury ☐ Pituitary Dwarfism ☐ Pulled/Strained Muscle ☐ Spina Bifida ☐ Other Back/Neck Disorder ☐ Other _____
2 Mental Health/ Substance Abuse ☐ Yes ☐ No	☐ Alcoholism ☐ Anxiety/Depression ☐ Attention Deficit Disorder ☐ Biploar/Manic Depression ☐ Drug Abuse ☐ Eating Disorder ☐ Suicide Attempt ☐ Other _____
3 Transplant ☐ Yes ☐ No	☐ Bone Marrow ☐ Discussed Possible Future Transplant ☐ Organ _____
4 Medication ☐ Yes ☐ No	☐ Current Medications ☐ Medications Taken Within the Past Year
5 Other ☐ Yes ☐ No	☐ Abnormal Test or Physical Results ☐ Condition or Congenital Disorder Not Mentioned Above ☐ Treatment or Surgery Discussed or Advised, But Not Yet Done ☐ Unexplained Weight Change

Please give details below (if additional space is required, please attach a separate sheet with your name).

Question #	Person	Condition/Diagnosis	Treatment/Complications	Physician's Name	Dates Treated	Prognosis

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