Request for Individual/Family Health Quote

Please complete this form in its entirety, and email to: BenefitOptions@comcast.net
Or print and fax completed form to: 1-866-315-7120 (toll free)
For questions regarding this form, call ☎ 303-914-0159

General Information

Name ______
Address ______
City ______ Colorado
Zipcode ______
Phone Day ______ Evening ______
Email Address: ______
Self-employed? ☐ Yes ☐ No How long? ______

Family Information

	Gender	Date of Birth	Tobacco Use
Policy Holder	☐ Male ☐ Female		☐ Yes ☐ No
Spouse	☐ Male ☐ Female		☐ Yes ☐ No
Child	☐ Male ☐ Female		☐ Yes ☐ No
Child	☐ Male ☐ Female		☐ Yes ☐ No
Child	☐ Male ☐ Female		☐ Yes ☐ No

Known Health Conditions?*	
Medication(s) taking	

* example(s)= Asthma, Allergies, High Cholesterol (>220), High Blood Pressure (>140/90), Heart condition, Cancer, Hospitalizations, Height/Weight not proportionate.

Current Insurance

This section will help us give you a more accurate comparison.

Company ______ Deductible ______
Office Copay ______ Coinsurance ______
Prescription ______ Out-of-pocket Max. ______
Type of current plan ☐ HMO ☐ PPO
Why are you shopping? ☐ Price ☐ Benefits ☐ Service
Current Rates
Renewal Rates

Please quote the following

Preferred Options:

Office Copay
Maximum Deductible[1] Choose Prescription ______
Your coinsurance % [2] Choose Other ______

☐ I would like information on a dental plan
☐ I would like a quote for life insurance

Comments: ______