



Please complete the information below return to:
 Harbour Health Insurance Solutions
 Fax #: (843) 671-9201
 Email: info@hhisolutions.com
 Any Questions, Please call:
 Harbour Health Insurance Solutions at (843) 671-9200

Individual/Family Insurance Proposal Request Form

Name: _____

Address: _____

County: _____ Phone: _____ Fax: _____

Email: _____ • DOB: _____ • Sex: M / F

Any tobacco use in the past 12 months: Y / N: If Yes what form tobacco: _____

Height: _____ ft. _____ in. • Weight: _____ lbs. • Marital Status: Single / Married / Divorced / Widowed

List all prescriptions & dosage: _____

List all treatment for any medical condition(s) in the past 5 years (please list & explain details): _____

Current Insurance Co.: _____ Request Effective/Start Date: _____

Requested Coverage Details: Medical Ins.: Y / N Dental Ins.: Y / N Vision Ins.: Y / N Life Ins.: Y / N

Medical Insurance Details: Deductible Range: Min. \$ _____ Max. \$ _____

Dr. Visits: \$ _____ Co-pay (or) part of deductible • Prescription Drugs: \$ _____ Co-pay (or) part of deductible

Requested Cost Per Month: Minimum \$ _____ Maximum \$ _____

List your spouse and children's information if you would like them to be quoted for coverage as well:

Spouse: Name: _____ • DOB: _____ • Sex: M / F

Any tobacco use in the past 12 months: Y / N: If Yes what form tobacco: _____

Height: _____ ft. _____ in. • Weight _____ lbs. List all prescriptions & dosage: _____

Treatment for any medical condition(s) in the past 5 years (please list & explain details): _____

Children:

• Name: _____ DOB: _____ • Sex: M / F List all prescriptions & dosage: _____

Treatment for any medical condition(s) in the past 5 years (please list & explain details): _____

• Name: _____ DOB: _____ • Sex: M / F List all prescriptions & dosage: _____

Treatment for any medical condition(s) in the past 5 years (please list & explain details): _____

Please attach a separate page with any additional information.