



# Request for Individual Major Medical Quote

P O Box 29189  
 Shawanee Mission, KS 66201  
 P: 888-402-7204  
 F: 913-945-4393  
 E: brokerage@alliednational.com

## BROKER INFORMATION

Date:

BROKER NAME		PHONE
AGENCY NAME		FAX NUMBER
ADDRESS		E-MAIL ADDRESS
CITY	STATE	ZIP

## PROPOSAL REQUEST

DATE REQUIRED:		EFFECTIVE DATE	
NAME:		CITY, STATE, ZIP	
OCCUPATION	DOB	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DOES NOT USE TOBACCO <input type="checkbox"/> USES TOBACCO <input type="checkbox"/>
SPOUSE DOB	DOES NOT USE TOBACCO <input type="checkbox"/> USES TOBACCO <input type="checkbox"/>	SPOUSE OCCUPATION:	NUMBER OF CHILDREN:

## CURRENT INFORMATION

Current carrier:	
Deductible:	
Coinsurance:	
Copay:	
PPO Network:	
Rx benefit:	
Current Premium:	
Health Considerations:	
Reason for changing:	

## WHAT ARE YOU LOOKING FOR?

Deductible:	
Coinsurance:	
Copay:	
PPO Network:	
Rx benefit:	
Is this an HSA?	

⑩ FAX PROPOSAL TO:	⑩ E-MAIL PROPOSAL TO:
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