

# BLACK, GOULD & ASSOCIATES, INC.

## INDIVIDUAL QUOTE REQUEST



DATE: \_\_\_\_\_

### AGENT INFORMATION

AGENT'S NAME: \_\_\_\_\_ AGENT'S EMAIL: \_\_\_\_\_

AGENT'S PHONE: \_\_\_\_\_ AGENT'S FAX: \_\_\_\_\_

### CLIENT INFORMATION

CLIENT NAME: \_\_\_\_\_ CLIENT ZIP CODE: \_\_\_\_\_

CLIENT COUNTY: \_\_\_\_\_ CLIENT STATE: \_\_\_\_\_

### CENSUS

MALE AGE \_\_\_\_\_ SMOKER \_\_\_\_\_ FEMALE AGE \_\_\_\_\_ SMOKER \_\_\_\_\_

CHILD AGE \_\_\_\_\_

### PRODUCT INFORMATION

HMO'S \_\_\_\_\_ PPO'S - \$500 \_\_\_\_\_ PPO'S - \$1,000 \_\_\_\_\_

PPO'S - \$1,500 \_\_\_\_\_ PPO'S - \$2,500 \_\_\_\_\_ PPO'S - \$5,000 \_\_\_\_\_

HSA'S \_\_\_\_\_

### Are there specific providers desired in the network quoted?

FULL DOCTOR NAME: \_\_\_\_\_ SPECIALTY: \_\_\_\_\_

FULL DOCTOR NAME: \_\_\_\_\_ SPECIALTY: \_\_\_\_\_

Does your client have any pre-existing medical conditions? Yes \_\_\_\_\_ No \_\_\_\_\_

*If yes, please complete the Individual Medical Questionnaire*

You may fax your request to \_\_\_\_\_ at \_\_\_\_\_ or email \_\_\_\_\_

If you would like to see our individual product portfolio, or would like to use our individual rater, check out our website at

[www.blackgould.com](http://www.blackgould.com)

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