



Individuals & Families QUOTE REQUEST FORM

Please complete the form below to receive a free quote. Please include a return phone number and notes on when is the best time to contact you.

Full Name:

Address:

Address (cont'd):

City:

State: North Carolina South Carolina Virginia
 Other US State

Zip: Phone:

Work Phone: Fax:

Email:

WHO WILL BE INSURED?

	Name	Age	DOB (mm/dd/yy)	Sex	
1.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Male	<input type="radio"/> Female
2.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Male	<input type="radio"/> Female
3.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Male	<input type="radio"/> Female
4.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Male	<input type="radio"/> Female
5.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Male	<input type="radio"/> Female

Are those to be insured fortunate to enjoy good health? Yes No

HAS ANYONE TO BE INSURED HAD ANY OF THE FOLLOWING HEALTH CONDITIONS?

- Heart Trouble?: Yes No
- Cancer?: Yes No
- Diabetes?: Yes No
- High Blood Pressure?: Yes No
- Currently Pregnant?: Yes No

Answering yes does **NOT** disqualify you. If you responded **"Yes"** to any of these pre-existing health conditions, please explain below:

ADDITIONAL INFORMATION?

Marital Status:

- Married
- Single
- Divorced
- Widowed

Do You Smoke?:

- Yes
- No

I used to smoke, but have not had a cigarette in:

- Less than 6 months
- Less than 3 years
- More than 5 years
- Less than 1 year
- Less than 5 years
- Never

Does Your Spouse Smoke?:

- Yes
- No

My spouse used to smoke, but has not had a cigarette in:

- Less than 6 months
- Less than 3 years
- More than 5 years
- Less than 1 year
- Less than 5 years
- Never

Do You Need Maternity Coverage?:

- Yes
- No

My current insurance is effective through:

My current insurance has been: Dropped Cancelled

TYPE OF COVERAGE DESIRED?

Major Medical:	<input type="radio"/> Yes	<input type="radio"/> No
PPO (Preferred Provider Organization):	<input type="radio"/> Yes	<input type="radio"/> No
HMO (Health Maintenance Organization):	<input type="radio"/> Yes	<input type="radio"/> No
Long Term Disability:	<input type="radio"/> Yes	<input type="radio"/> No
Long Term Care (Assisted Living):	<input type="radio"/> Yes	<input type="radio"/> No
Medicare Supplement:	<input type="radio"/> Yes	<input type="radio"/> No
Life Insurance:	<input type="radio"/> Yes	<input type="radio"/> No

JWB INSURANCE

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