

REQUEST FOR MARKET SEARCH
Individual Quote Request for Multiple Carriers

Contact Name: _____ **-E-Mail Address:** _____

Date Submitted: _____ **-Requested Effective Date:** _____

Please indicate type of market search you are requesting:	
<input type="checkbox"/> Individual Health	<input type="checkbox"/> Long Term Disability
<input type="checkbox"/> Office Overhead – thru Prudential only	<input type="checkbox"/> Term Life
<input type="checkbox"/> Dental	<input type="checkbox"/> Long Term Care

Currently insured on SBOTIT Individual Aetna Plan?	_____ Yes _____ No
What type of coverage do you currently have?	Individual Group _____ Rate: \$ _____ Carrier: _____
What type of PPO plan are you looking for?	With office co-pays? _____ Deductible Amount _____ H S A Compatible Plan _____
Effective Date _____	Yes: _____ No: _____ Between: \$ _____ and \$ _____ Yes _____ Deductible: \$ _____ No _____

Please check one:	_____ Employee _____ Attorney _____ Other
Applicant's Name:	_____
Spouse Name:	_____
Address City, state, Zip	_____

Phone: _____	Fax: _____																																			
<table border="1"> <tr> <th>Applicant DOB</th> <th>Height</th> <th>Weight</th> <th>M</th> <th>F</th> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table>	Applicant DOB	Height	Weight	M	F						<table border="1"> <tr> <th>Child(ren) DOB</th> <th>Height</th> <th>Weight</th> <th>M</th> <th>F</th> </tr> <tr> <td>1-</td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td>2-</td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td>3-</td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td>4-</td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table>	Child(ren) DOB	Height	Weight	M	F	1-					2-					3-					4-				
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List current Medical Conditions:	Applicant: _____												
	Spouse: _____												
	Child(ren): _____												
Tobacco Use? If yes, what type?	<table border="1"> <tr> <td>Applicant</td> <td>_____</td> <td>Yes</td> <td>_____</td> <td>No</td> <td>_____</td> </tr> <tr> <td>Spouse</td> <td>_____</td> <td>Yes</td> <td>_____</td> <td>No</td> <td>_____</td> </tr> </table>	Applicant	_____	Yes	_____	No	_____	Spouse	_____	Yes	_____	No	_____
Applicant	_____	Yes	_____	No	_____								
Spouse	_____	Yes	_____	No	_____								
Maternity Coverage Needed	Yes _____ No _____												
Anyone Currently Pregnant?	Yes _____ No _____												

How did you hear about us? ___ Direct Mail ___ Seminars ___ Web links ___ Publication/Ads
 ___ Our Web Site ___ Word of Mouth ___ Trust Staff

You may fax this completed form to the SBIT Insurance Agency at 512-479-4109 in order to expedite your quote request.