

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
	Yes: _____ No: _____	Between: \$ _____ and \$ _____	Yes _____ Deductible: \$ _____ No _____
Effective Date _____			

Please check one:	<input type="checkbox"/> Employee	<input type="checkbox"/> Attorney	<input type="checkbox"/> Other
Applicant's Name:	_____		
Spouse/Domestic Partner 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> <tr> <th>Spouse/DP* 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						Spouse/DP* 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-				
Applicant DOB	Height	Weight	M	F																																										
Spouse/DP* DOB	Height	Weight	M	F																																										
Child(ren) DOB	Height	Weight	M	F																																										
1-																																														
2-																																														
3-																																														
4-																																														

List current Medical Conditions:	Applicant: _____
	Spouse/Domestic Partner: _____
	Child(ren): _____

Tobacco Use? If yes, what type?	Applicant	Yes	No
	Spouse/DP*	Yes	No
Maternity Coverage Needed	Yes _____	No _____	

Anyone Currently Pregnant?	Yes _____	No _____
----------------------------	-----------	----------

How did you hear about us? Direct Mail Seminars Web links Our Website Trust Staff
 Word of Mouth Austin Bar Journal Dallas Bar Headnotes Houston Lawyer
 Texas Bar Journal Texas Lawyer Texas Paralegal Journal

* Domestic Partner

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

RED = REQUIRED WHEN APPLICABLE