

**Borshoff & Associates**

Brian J. Borshoff, LUTCF  
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**FAMILY HEALTH INSURANCE PRESREEN SHEET****Family Information**

*(All dependents must be listed whether or not applying for coverage. Children age 19 to 25 must be attending an accredited college full-time and be claimed as a dependent for income tax purposes to be eligible for coverage.)*

| Relationship | Name | Gender   | Date of Birth<br>MM/DD/YYYY | Height | Weight | Smoker?   | Waiving<br>Coverage?  |
|--------------|------|--|-----------------------------|--------|--------|---|---|
| Primary      |      | <input type="checkbox"/> Male<br><input type="checkbox"/> Female | ____/____/____              |        |        | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| Spouse       |      | <input type="checkbox"/> Male<br><input type="checkbox"/> Female | ____/____/____              |        |        | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| Dependent    |      | <input type="checkbox"/> Male<br><input type="checkbox"/> Female | ____/____/____              |        |        | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| Dependent    |      | <input type="checkbox"/> Male<br><input type="checkbox"/> Female | ____/____/____              |        |        | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| Dependent    |      | <input type="checkbox"/> Male<br><input type="checkbox"/> Female | ____/____/____              |        |        | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| Dependent    |      | <input type="checkbox"/> Male<br><input type="checkbox"/> Female | ____/____/____              |        |        | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| Dependent    |      | <input type="checkbox"/> Male<br><input type="checkbox"/> Female | ____/____/____              |        |        | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| Dependent    |      | <input type="checkbox"/> Male<br><input type="checkbox"/> Female | ____/____/____              |        |        | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| Dependent    |      | <input type="checkbox"/> Male<br><input type="checkbox"/> Female | ____/____/____              |        |        | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |

**Address Information****Phone Information**

|         |  |               |  |
|---------|--|---------------|--|
| Address |  | Home Phone    |  |
| City    |  | Work Phone    |  |
| State   |  | Fax           |  |
| Zip     |  | Other (_____) |  |

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**Health Insurance Options**

|  |  |  |
|--|--|--|
| Deductible   | <input type="checkbox"/> \$250<br><input type="checkbox"/> \$500<br><input type="checkbox"/> \$750<br><input type="checkbox"/> \$1,000<br><input type="checkbox"/> \$2,000 | <input type="checkbox"/> \$3,000<br><input type="checkbox"/> \$5,000<br><input type="checkbox"/> \$10,000<br><input type="checkbox"/> _____  |
| Benefit Percentage   | <input type="checkbox"/> 100/70%<br><input type="checkbox"/> 90/80%<br><input type="checkbox"/> 90/70%<br><input type="checkbox"/> 90/60%                                  | <input type="checkbox"/> 80/60%<br><input type="checkbox"/> 80/50%<br><input type="checkbox"/> 70/50%<br><input type="checkbox"/> ____/____% |
| Benefit Percentage Limit   | <input type="checkbox"/> \$3,500<br><input type="checkbox"/> \$5,000   | <input type="checkbox"/> \$_____   |
| Co-Payment Option  | <input type="checkbox"/> \$10<br><input type="checkbox"/> \$20   | <input type="checkbox"/> \$30<br><input type="checkbox"/> \$_____  |
| Preventive Care Option   | <input type="checkbox"/> Yes<br>\$_____ amount   | <input type="checkbox"/> No  |
| Maternity  | <input type="checkbox"/> Yes   | <input type="checkbox"/> No  |
| Supplemental Accident  | <input type="checkbox"/> Yes<br>\$_____ amount   | <input type="checkbox"/> No  |
| Mental Disorders   | <input type="checkbox"/> Yes   | <input type="checkbox"/> No  |
| Substance Abuse  | <input type="checkbox"/> Yes   | <input type="checkbox"/> No  |
| Deductible Carryover   | <input type="checkbox"/> Yes   | <input type="checkbox"/> No  |
| 24 Hour Occupational Coverage<br><i>(Applies to both Medical and Dental)</i> | <input type="checkbox"/> Yes   | <input type="checkbox"/> No  |
| Prescription Drug Card   | <input type="checkbox"/> Yes<br>\$_____ Generic<br>\$_____ Name Brand  | <input type="checkbox"/> No  |
| Dental   | <input type="checkbox"/> Yes<br><input type="checkbox"/> With Ortho<br><input type="checkbox"/> Without Ortho  | <input type="checkbox"/> No  |
| Did you have Prior Dental Insurance?   | <input type="checkbox"/> Yes   | <input type="checkbox"/> No  |
| Vision   | <input type="checkbox"/> Yes   | <input type="checkbox"/> No  |



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**Medical History**

*(The following questions pertain to you and any eligible dependents, whether or not applying for coverage.)*

|  |                          |                          |
|--|--------------------------|--------------------------|
| 1. Within the last 5 year have you or your dependents:   | <b>Yes</b>               | <b>No</b>                |
| a. Consulted any doctor, counselor or therapist?   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Been hospitalized or undergone any medical testing or treatment?                            | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Been advised of the need for any future treatment or surgery?                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you or any of your dependents currently pregnant? Due Date: ____/____/____              | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you or any of your dependents currently taking medication?                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you or any of your dependents filed any claims over \$2,000 within the last 24 months? | <input type="checkbox"/> | <input type="checkbox"/> |

*FOR ANY "YES" ANSWERS IDENTIFIED ABOVE, PLEASE PROVIDE COMPLETE DETAILS.*

| Q # | Person | Illness and<br>or Diagnosis | Dates |    | Type of<br>Treatment or<br>Surgery | Medication | Dosage |
|-----|--------|-----------------------------|-------|----|------------------------------------|------------|--------|
|     |        |                             | From  | To |                                    |            |        |
|     |        |                             |       |    |                                    |            |        |
|     |        |                             |       |    |                                    |            |        |
|     |        |                             |       |    |                                    |            |        |
|     |        |                             |       |    |                                    |            |        |
|     |        |                             |       |    |                                    |            |        |
|     |        |                             |       |    |                                    |            |        |
|     |        |                             |       |    |                                    |            |        |

**Detail and Additional Comments:**