

**Borshoff & Associates**

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INDIVIDUAL HEALTH INSURANCE PRESCREEN SHEET**Individual Information**

Name	Gender	Date of Birth MM/DD/YYYY	Height	Weight	Smoker?
	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /			<input type="checkbox"/> Yes <input type="checkbox"/> No

Address Information**Phone Information**

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

Health Insurance Options

Deductible	<input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000	<input type="checkbox"/> \$3,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> _____
Benefit Percentage	<input type="checkbox"/> 100/70% <input type="checkbox"/> 90/80% <input type="checkbox"/> 90/70% <input type="checkbox"/> 90/60%	<input type="checkbox"/> 80/60% <input type="checkbox"/> 80/50% <input type="checkbox"/> 70/50% <input type="checkbox"/> ____ / ____ %
Benefit Percentage Limit	<input type="checkbox"/> \$3,500 <input type="checkbox"/> \$5,000	<input type="checkbox"/> \$ _____
Co-Payment Option	<input type="checkbox"/> \$10 <input type="checkbox"/> \$20	<input type="checkbox"/> \$30 <input type="checkbox"/> \$ _____
Preventive Care Option	<input type="checkbox"/> Yes \$ _____ amount	<input type="checkbox"/> No
Maternity	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Supplemental Accident	<input type="checkbox"/> Yes \$ _____ 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 <i>(Applies to both Medical and Dental)</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prescription Drug Card	<input type="checkbox"/> Yes \$ _____ Generic \$ _____ Name Brand	<input type="checkbox"/> No
Dental	<input type="checkbox"/> Yes <input type="checkbox"/> With Ortho <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

1. Within the last 5 year have you:	Yes	No
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 currently pregnant? Due Date: ____ / ____ / ____	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking medication?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you 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 or Diagnosis	Dates		Type of Treatment or Surgery	Medication	Dosage
			From	To			

Detail and Additional Comments: