

REQUEST QUOTE APPLICATION FOR INDIVIDUAL / FAMILY COVERAGE

Complete Application and Fax To: 1-866-541-3535

OR

Mail To: Daveco & Associates Insurance 1022 SE 30th St. Cape Coral, Fl. 33904

PRIMARY INSURED Self Employed? Yes No *** Required Field**

Name * _____

Street _____ City * _____ State * _____ Zip Code * _____

Telephone Number * (____) _____ Fax: (____) _____ E-mail: _____

Sex * _____ Birthdate* _____ Height* _____ Weight * _____

When was your last physical exam? * _____ Used tobacco in the last year? * Yes No

SPOUSE (all questions required if spouse is included) Self Employed Yes No

Name * _____

Sex _____ Birthdate _____ Height _____ Weight* _____

When was your last physical exam? * _____ Used tobacco in the last year? * Yes No

CHILD(REN) (if over 18 must be full time student)

1. Name * _____ Sex * _____ Birthdate * _____ Height * _____ Weight * _____

2. Name * _____ Sex * _____ Birthdate * _____ Height * _____ Weight * _____

3. Name * _____ Sex * _____ Birthdate * _____ Height * _____ Weight * _____

4. Name * _____ Sex * _____ Birthdate * _____ Height * _____ Weight * _____

5. Name * _____ Sex * _____ Birthdate * _____ Height * _____ Weight * _____

In the past 5 years, has any applicant taken part in flying as a pilot, parachuting, hang gliding, underwater diving, auto racing, or driving or riding as a passenger on any type of motorcycle; Or does any applicant expect to take part in any of these activities in the next 2 years? If YES, specify who and which activities:

Yes No

Is any applicant or family member (whether or not listed on the application) currently pregnant? Yes No

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Current Health Insurance Coverage

Are the persons above currently insured? * Yes No If yes, are you on Cobra? Yes No

Name of current insurance company _____ Current monthly premium * _____

Current deductible amount _____ Maximum out-of pocket (if known) _____

The health questions below are for anyone that is applying for insurance!!! Your health history determines your insurability and your rates. In order to help us provide the most accurate quote, please notate any YES answers with appropriate details in the “Health Details” section.

HEALTH QUESTIONS: *

***Required Field**

- 1. Is any applicant currently taking medication or receiving medical treatment of any kind? Yes No
- 2. Has any applicant gained or lost 15 pounds or more within the last 12 months? Yes No
- 3. Has any life or health insurance application or policy on any applicant ever been voided, declined, canceled, postponed, or modified as to plans, amount or rate? Yes No

Has any applicant in the last 10 years had any indication, diagnosis or treatment of any disease or disorder of the:

- a. heart or circulatory system such as high blood pressure, anemia, heart attack, heart murmur chest pain, irregular heart beat, varicose veins, phlebitis or stroke? Yes No
- b. nervous system, such as epilepsy, seizure, convulsions, headaches, or paralysis? Yes No
- c. digestive system, such as ulcer, gastritis, intestinal disorders, colitis, hemorrhoids, bloody stools, or hernia, or of the esophagus, liver, pancreas, spleen or gallbladder? Yes No
- d. muscular or skeletal systems, such as arthritis, gout or any jaw, knee, back, joint, or spine disorder? Yes No
- e. lungs or respiratory system, such as allergies, asthma, bronchitis, tuberculosis, pneumonia or emphysema? Yes No
- f. bladder, kidney, or genitor-urinary system, such as urinary tract infections or blood in the urine? Yes No
- g. male or female reproductive organs, prostate problems, irregular menstruation, or abnormal pap test? Yes No
- h. eyes, ears, nose, mouth or throat, such as double vision, ear infection, deviated nasal septum, thrush or tonsillitis? Yes No
- i. tumor, cyst, polyp or growth of any kind? Yes No

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- j. skin disorder or disease? Yes No
- k. any blood abnormalities, including cholesterol or triglyceride abnormalities? Yes No
- l. immune system deficiencies or sexually transmitted diseases (excluding a positive test for HIV)? Yes No
- m. emotional or behavioral problems; anxiety, depression, nervousness or other psychiatric illnesses, suicide attempts or gestures, or consulted with a mental health professional? Yes No
- n. diabetes, sugar in the urine, blood, thyroid, breast (such as fibrocystic breast disease) or other gland disorders? Yes No
- o. cancer, leukemia or any type of malignancy, other disease, disorder or injury? Yes No
- p. been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex or Condition (ARC)? Yes No

Within the last 5 Years, has any applicant:

- 4. had any indication, diagnosis or treatment of alcohol or drug dependency, abuse or problem? Yes No
- 5. used any drug not prescribed, such as opiates and/or hallucinogens? Yes No
- 6. discussed or been advised to have testing, consultations or surgery that have not been completed? Yes No
- 7. has any applicant had any indication, diagnosis, or treatment of any disease, disorder or injury not previously referenced? If yes, give name and cause: Yes No

HEALTH DETAILS

Question Number	Person's First Name	Symptoms / Condition	Dates	Treatment, Advice Given, Results. and Other Details

GOOD HEALTH DISCOUNTS. An adult may qualify for preferred discounts if (s)he has not health related history warranting adverse underwriting action. Preferred Class can **SAVE** an extra **10%** to **15%** of premium.