

## Exchange State Bank & Insurance Individual Health Insurance Quote Request

Please complete this quote request and turn it in to an Exchange State Bank Insurance agent for your no obligation Health Insurance Quote for Iowa residents. Please print out and fax the completed form to 641-742-3424, or bring your completed copy by one of our offices to leave with a representative. We will contact you promptly for any additional information that may be required.

*\* indicates required fields.*

Name \* \_\_\_\_\_

Address \* \_\_\_\_\_

City \* \_\_\_\_\_

State Iowa

Zip \* \_\_\_\_\_

Home Phone \* \_\_\_\_\_

Business Phone \_\_\_\_\_

Fax Number \_\_\_\_\_

E-mail Address \* \_\_\_\_\_

Best time to contact you:    \_\_\_ Daytime  
  \_\_\_ Evening

### Information about you:

Full Name \_\_\_\_\_

Gender \_\_\_ Male   \_\_\_ Female

Date of Birth \_\_\_ / \_\_\_ / \_\_\_ (MM/DD/YYYY)

Height \_\_\_ ft. \_\_\_ in.

Weight \_\_\_\_\_ lbs.

Tobacco user? \_\_\_ Yes   \_\_\_ No

**Information about spouse: (if applicable)**

Full Name \_\_\_\_\_

Gender  Male  Female

Date of Birth \_\_\_/\_\_\_/\_\_\_ (MM/DD/YYYY)

Height \_\_\_ ft. \_\_\_ in.

Weight \_\_\_\_\_ lbs.

Tobacco user?  Yes  No

**Deductible**  300  
 500  
 1000  
 2500

**Coinsurance**  90/10  
 80/20  
 50/50

**General Information**

Who will this request cover?

- Self
- Self & Spouse
- Self, Spouse & Child(ren)
- Self & Children
- Children only

What is your marital status?

- Single
- Married
- Sepreated

How many dependent children will be included?

- None  Four
- One  Five
- Two  Six
- Three

Are you, your spouse, or any dependents now pregnant?

- Yes  
 No

What is your specific occupation? \_\_\_\_\_

What optional coverage's would you like?

- Maternity  
 Prescription Drug Card  
 Contraceptive Coverage  
 Dental  
 Supplemental Accident Option  
 Chiropractic Care

**Medical Questions**

To see those plans for which you may qualify, please answer the following questions:

Have you, your spouse, or your dependents had any health symptoms relating to the conditions listed below within the last 5 years? (If yes, please check the blank next to the specific condition(s) listed below that any individual, for which you are requesting coverage, has been told they have or have received treatment)

<p><b>Central Nervous System</b></p> <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Epilepsy <input type="checkbox"/> Seizure Disorders <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Other Demyelinating Disorders	<p><b>Skin, Bones, or Muscles</b></p> <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Melanoma <input type="checkbox"/> Lupus <input type="checkbox"/> Joint Replacement <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Spinal Disc Disorders	<p><b>Mental Health, Substance Abuse</b></p> <input type="checkbox"/> Alcoholism <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Psychiatric Disorders <input type="checkbox"/> Manic Depression
<p><b>Circulatory System</b></p> <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Stroke <input type="checkbox"/> TIA <input type="checkbox"/> Heart Disease/Bypass Surgery <input type="checkbox"/> Peripheral Vascular Disease	<p><b>Digestive System</b></p> <input type="checkbox"/> Liver Disease <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Ulcerative Colitis	<p><b>Respiratory System</b></p> <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Chronic Bronchitis <input type="checkbox"/> COPD
<p><b>Other</b></p> <input type="checkbox"/> Infertility <input type="checkbox"/> Breast Cancer <input type="checkbox"/> Uterine Disorders <input type="checkbox"/> Diabetes	<input type="checkbox"/> Leukemia <input type="checkbox"/> Lymphoma <input type="checkbox"/> Fatigue Disorders	<input type="checkbox"/> AIDS & AIDS – related <input type="checkbox"/> HIV <input type="checkbox"/> Other Cancer

Please describe any other health conditions not listed above:

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*You may be eligible for coverage under HIPAA.* The following questions will help determine your eligibility, which could improve coverage of the pre-existing conditions indicated above:

Has your most recent health coverage been through a group health plan, an individual health plan, a government health plan (or health insurance offered in connection with such plans)

Yes  
 No

Are you eligible for coverage under a group health plan, Medicare, or Medicaid?

Yes  
 No

Do you have any other health insurance coverage?

Yes  
 No

Have you had your most recent coverage canceled for your nonpayment of premiums or your fraud?

Yes  
 No

If continuation coverage is available under your prior plan (such as federal "Cobra" law or a similar state law), have you elected and will you have exhausted such continuation coverage by the Requested Effective Date?

Yes  
 No

If presently insured, what is the anticipated termination date of your coverage?

\_\_\_/\_\_\_/\_\_\_ (MM/DD/YY)

This is a request for quotation only. No coverage is in effect until bound by an insurance carrier. A licensed agent will respond to your submission as soon as possible.