



Individual Quote Request Form

*Required fields

*Name _____ M-F *Tobacco Use: Y/N Ht. _____ Wt. _____

*DOB/Age _____

*Spouse _____ M-F *Tobacco Use: Y/N Ht. _____ Wt. _____

*DOB/Age _____

*State _____ *Zip code _____

Number of Children _____

* DOB/Age(s)/Gender of Child(ren) _____

Carrier(s) requested: _____

Please circle plan design requested: PPO HDHP/HSA HMO (HMO's are only available in CA)

Co-insurance 100 90/10 80/20 70/30 60/40 50/50

Deductible \$0 - \$250 \$500 - \$1000 \$1500 - \$2500 \$3500- \$5000 - or higher _____

Desired Premium Range \$ _____

Select Options:	Office Visit Co-Pay	Yes	No
	Prescription coverage	Yes	No
	Maternity Rider	Yes	No (Not offered by all carriers)
	Dental	Yes	No (Not offered by all carriers)

*Agent Name & Phone: BEACH CITIES INSURANCE SERVICES _____

* Agent's e-mail address bryan@beachins.com / Fax (949)720-1489 _____

Delivery options: E-Mail summary /Fax summary

Additional Information _____

