Individual and Family Insurance Quote Request

Please include all members of your immediate family. Please fill out as completely as possible.

First Name:	Last Name:	Date of Birth:	
Address:	City:	State:	Zip:
Home Telephone: ( )	Daytime Telephone: ( )	E-mail address:	
Check one : ☐ Male ☐ Female	Tobacco Use in the Past Year? ☐ Yes ☐ No	Height: ft. inches	Weight:
Please list any medications taken, including types and dosages:			
Please list any major health concerns and conditions:			

Please complete the following information for your spouse, if applicable:

Check one : ☐ Male ☐ Female	Spouse's Date of Birth:	Tobacco Use in the Past Year? ☐ Yes ☐ No	Height: ft. inches	Weight:
Please list any medications taken, including types and dosages for your spouse:				
Please list any major health concerns and conditions for your spouse:				

Please see page two for information regarding children.

Please complete the following information for your children, if applicable:

Child One:

Check one : ☐ Male ☐ Female	Child's Date of Birth:	Tobacco Use in the Past Year? ☐ Yes ☐ No	Height: ft. inches	Weight:
Please list any medications taken, including types and dosages for this child:				
Please list any major health concerns and conditions for this child:				

Child Two:

Check one : ☐Male ☐Female	Child's Date of Birth:	Tobacco Use in the Past Year? ☐Yes ☐No	Height: ft. inches	Weight:
Please list any medications taken, including types and dosages for this child:				
Please list any major health concerns and conditions for this child:				

Child Three:

Check one : ☐Male ☐Female	Child's Date of Birth:	Tobacco Use in the Past Year? ☐Yes ☐No	Height: ft. inches	Weight:
Please list any medications taken, including types and dosages for this child:				
Please list any major health concerns and conditions for this child:				

Child Four:

Check one : ☐Male ☐Female	Child's Date of Birth:	Tobacco Use in the Past Year? ☐Yes ☐ No	Height: ft. inches	Weight:
Please list any medications taken, including types and dosages for this child:				
Please list any major health concerns and conditions for this child::				

(Please photocopy page two if you need space for more than four children.)

What other types of coverage would you information about in addition to health insurance?

☐ Life Insurance ☐ Dental ☐ Disability ☐ Vision ☐ Cancer Plan ☐ Not Sure ☐ None

Ohio Health Insurance Options

Please mail or fax to Ohio Health Insurance Options, P.O. Box 1481 Reynoldsburg, OH 43068

Phone Number 614-737-3804 Toll-free 1-888-217-4172 Fax Number: 614-737-3805