

BRACKETT INSURANCE CONSULTANTS INC.

Life ♦ Health ♦ Disability ♦ Long Term Care

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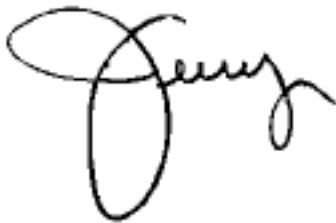
INSTRUCTIONS FOR REQUESTING A QUOTE

Anyone can email you a proposal... but we prefer to give you an ACCURATE rate so there are no surprises. To do so, we need to know something about your company and your employees.

1. The next page gives us the info about your company. This is the big picture that gets us started. Please complete this page as completely as possible.
2. The last two pages are needed to provide us with detailed medical info for pre-underwriting. **Make a copy of these two pages for each employee needing coverage.**
3. **Once all employees return turn in their forms, please fax over to 770-967-0372.** *(Your employees are welcome to fax their info directly to our office for confidentiality purposes.)*

We'll jump right on it and get you the info within 1-3 days... depending on the medical info provided. From that point we are at the mercy of the insurance company underwriting personnel.

Our staff is looking forward to taking very good care of you!



Jerry Brackett
President

GROUP HEALTH INSURANCE EMPLOYEE DATA

BUSINESS NAME _____

EMPLOYEE				
FIRST NAME	MIDDLE INITIAL	LAST NAME	SEX	HOME COUNTY
HOME ZIP CODE	HOME TELEPHONE		HEIGHT	WEIGHT
DATE OF BIRTH	CURRENT AGE	USE TOBACCO?	HEALTH INSURANCE COMPANY CURRENTLY USING	

LIST ALL MINOR HEALTH PROBLEMS FROM PAST 12 MONTHS AND ANY MAJOR HEALTH PROBLEMS FROM PAST 10 YEARS
(Example: Cancer, Allergies, High Blood Pressure, Elevated Cholesterol, Heart, Cysts, Diabetes, Etc.) Include date of onset/recovery and treatment.

SPOUSE (IF NEEDING COVERAGE)

FIRST NAME	MIDDLE INITIAL	LAST NAME	SEX	
DATE OF BIRTH	CURRENT AGE	USE TOBACCO?	HEIGHT	WEIGHT

LIST ALL MINOR HEALTH PROBLEMS FROM PAST 12 MONTHS AND ANY MAJOR HEALTH PROBLEMS FROM PAST 10 YEARS
(Example: Cancer, Allergies, High Blood Pressure, Elevated Cholesterol, Heart, Cysts, Diabetes, Etc.) Include date of onset/recovery and treatment.

#1 CHILD (IF NEEDING COVERAGE)

FIRST NAME	MIDDLE INITIAL	LAST NAME	SEX	
DATE OF BIRTH	CURRENT AGE	USE TOBACCO?	F.T. STUDENT?	HEIGHT
				WEIGHT

LIST ALL MINOR HEALTH PROBLEMS FROM PAST 12 MONTHS AND ANY MAJOR HEALTH PROBLEMS FROM PAST 10 YEARS
(Example: Cancer, Allergies, High Blood Pressure, Elevated Cholesterol, Heart, Cysts, Diabetes, Etc.) Include date of onset/recovery and treatment.

GROUP HEALTH INSURANCE EMPLOYEE DATA

(If insuring more than 4 children, feel free to photocopy this page as necessary.)

BUSINESS NAME _____

EMPLOYEE NAME _____

#2 CHILD (IF NEEDING COVERAGE)

FIRST NAME		MIDDLE INITIAL		LAST NAME		SEX
DATE OF BIRTH	CURRENT AGE	USE TOBACCO?	F.T. STUDENT?	HEIGHT	WEIGHT	

LIST ALL MINOR HEALTH PROBLEMS FROM PAST 12 MONTHS AND ANY MAJOR HEALTH PROBLEMS FROM PAST 10 YEARS
 (Example: Cancer, Allergies, High Blood Pressure, Elevated Cholesterol, Heart, Cysts, Diabetes, Etc.) Include date of onset/recovery and treatment.

#3 CHILD (IF NEEDING COVERAGE)

FIRST NAME		MIDDLE INITIAL		LAST NAME		SEX
DATE OF BIRTH	CURRENT AGE	USE TOBACCO?	F.T. STUDENT?	HEIGHT	WEIGHT	

LIST ALL MINOR HEALTH PROBLEMS FROM PAST 12 MONTHS AND ANY MAJOR HEALTH PROBLEMS FROM PAST 10 YEARS
 (Example: Cancer, Allergies, High Blood Pressure, Elevated Cholesterol, Heart, Cysts, Diabetes, Etc.) Include date of onset/recovery and treatment.

#4 CHILD (IF NEEDING COVERAGE)

FIRST NAME		MIDDLE INITIAL		LAST NAME		SEX
DATE OF BIRTH	CURRENT AGE	USE TOBACCO?	F.T. STUDENT?	HEIGHT	WEIGHT	

LIST ALL MINOR HEALTH PROBLEMS FROM PAST 12 MONTHS AND ANY MAJOR HEALTH PROBLEMS FROM PAST 10 YEARS
 (Example: Cancer, Allergies, High Blood Pressure, Elevated Cholesterol, Heart, Cysts, Diabetes, Etc.) Include date of onset/recovery and treatment.

PLEASE FAX THIS FORM TO: 770-967-0372