



Individual New Business Inquiry

FAX to Underwriting Department (805) 713-8847



INDIVIDUAL INFORMATION

Name of Applicant		Social Security or ID No.	
Agent George Moore	Agent ID No. J K K L P P P S R Z	Date Inquiry Submitted/Faxed	Requested Effective Date

REQUIRED INFORMATION Agent Phone No. (562) 431-5575 Agent FAX No. ()

BC Life & Health Products <input type="checkbox"/> Basic PPO 1000 (7900) <input type="checkbox"/> Basic PPO 1000 without Life (PE25) <input type="checkbox"/> Basic PPO 2500 (R418) <input type="checkbox"/> Basic PPO 2500 without Life (R419) <input type="checkbox"/> PPO Saver (NM31) <input type="checkbox"/> PPO Saver without Life (PE27) <input type="checkbox"/> 3500 Deductible PPO (R420) <input type="checkbox"/> CORE 5000 (DL96) <input type="checkbox"/> PPO Share 1000 (1930) <input type="checkbox"/> PPO Share 5000 (H062) <input type="checkbox"/> PPO Share 500 (1929) <input type="checkbox"/> PPO 3500 (HSA-Compatible) (T160) <input type="checkbox"/> Tonik 5000 (T775) <input type="checkbox"/> RightPlan PPO 40-Generic Rx (PE48) <input type="checkbox"/> Tonik 3000 (T774) <input type="checkbox"/> RightPlan PPO 40-Comprehensive Rx (PE49) <input type="checkbox"/> Tonik 1500 (T773) <input type="checkbox"/> RightPlan PPO 40-No Rx (P958) <input type="checkbox"/> _____		Blue Cross of California Products <input type="checkbox"/> PPO Share 2500 (7891) <input type="checkbox"/> PPO Share 1500 (7889) <input type="checkbox"/> PPO Share 1000 (1393) <input type="checkbox"/> PPO Share 500 (7895) <input type="checkbox"/> EPO (HSA-Compatible) (7892) <input type="checkbox"/> SelectHMO (PE43) <input type="checkbox"/> HMO Saver (7896) <input type="checkbox"/> Individual HMO (7898)
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MEDICAL CONDITIONS (Please do not submit medical records at this time)

APPLICANT DATA					DEPENDENT DATA				
<input type="checkbox"/> Male	Age	Height	Weight	Smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Male	Age	Height	Weight	Smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No
Specific Diagnosis and Date of Onset					Specific Diagnosis and Date of Onset				
Date(s) of Treatment					Date(s) of Treatment				
Date of Full Recovery					Date of Full Recovery				
Current Medication(s)/Dosages					Current Medication(s)/Dosages				

GENERAL CONCERNS AND QUESTIONS

UNDERWRITING RESPONSE

<input type="checkbox"/> Possible Level I + 20% <input type="checkbox"/> Possible Level I + 25% <input type="checkbox"/> Possible Level I + 50% <input type="checkbox"/> Possible Level I + 75% <input type="checkbox"/> Possible Level I + 100% <input type="checkbox"/> Possible MRMIP	Notes:
Underwriter	Date

Indications resulting from this inquiry are preliminary and based solely upon the completeness and accuracy of the information provided, and are subject to change based upon further review and additional information provided or not disclosed. If you are submitting this case, please be sure to include a copy of this inquiry and our response with the completed and signed applications. This response is no guarantee that your application will be approved. **Thank you!**