Application for Policy Quote

Select all that Apply

☐ Accident & Sickness ☐ Accident Only ☐ Critical Care ☐ Cancer Care

☐ Income Protector ☐ Sick Pay Plus – Accident & Sickness (3) Month ☐ Sick Pay Plus – Accident Only (6) Month ☐ Life

Full Name: _____

Address:_____

_____

Phone: _____

Cell: _____

eMail: _____

D.O.B: _____

Height: _____ **In** _____

Weight: _____

Occupation: _____

Annual Income: $_____

Name & Address of Employer: _____

_____

Hours Work/Week: _____

Driver's License #_____ **State** _____

List Medications: (If Any)_____

_____

Beneficiary Information

Beneficiary _____%_____ DOB ___/___/___

Relationship_____

Beneficiary_____%_____ DOB___/___/___

Relationship_____

Contingent Beneficiary_____%_____ DOB___/___/___

Relationship_____

Contingent Beneficiary_____%_____ DOB___/___/___

Relationship_____

[ONLY REQUIRED IF PURCHASING SPP/IP/CRIT CARE/LIFE]

Have you been seen or treated for Heart Attack, Diabetes, Stroke, and Cancer in the last 5 years:
Yes_____ No _____

Doctors Name:_____
Address: _____
Phone: _____

[COMPLETE ONLY IF PURCHASING A PLAN WITH SPOUSE OR CHILDREN]

Spouse First Name _____ Last _____ DOB __/___/____
Child First Name _____ Last _____ DOB __/___/____
Child First Name _____ Last _____ DOB __/___/____
Child First Name _____ Last _____ DOB __/___/____
Child First Name _____ Last _____ DOB __/___/____

[Payment Info] – Only complete when you are ready to make a purchase

Name of Bank_____
Bank Routing #_____
Bank Account#_____

Scan and Send Completed Packet to:

eMail: Dina.DiRoma@ia.Combined.Com

Mail to: Dina DiRoma
2011 Orinoco Drive
West Islip, NY 11795
Cell Ph. 516-426-3311