Insurance Fact Sheet

Today's Date:___________

WHEN COMPLETED, PLEASE RETURN TO THE FRONT DESK ALONG WITH YOUR MEDICARE CARD.

REFERRED BY ___________________________ PRIMARY AGENT ____________________________

NAME ____ **DOB** ________________________

SSN ____________________________________ **TOBACCO** Y or N **HT** _______ **WT** _______

H. PHONE _____________________ **EMAIL** ____

C. PHONE _____________________

SPOUSE ____ **DOB** ________________________

SSN ____________________________________ **TOBACCO** Y or N **HT** _______ **WT** _______

H. PHONE_____________________ **EMAIL** ____

C. PHONE _____________________

HOME ADDRESS ____

CITY_________________________ **STATE**__________ **COUNTY**___________ **ZIPCODE**_________________

P.O. BOX ______________________________ **CITY** _______________ **STATE** __________ **ZIP** ________________

PREFERRED NETWORK MERCY COX FREEMAN NO PREFERENCE

PREFERRED PHARMACY ____

PRIMARY CARE PHYSICIAN ____

PLEASE CHECK THE FOLLOWING GAP COVERAGE YOU WOULD LIKE TO DISCUSS WITH YOUR AGENT

DENTAL/VISION/HEARING _____	CRITICAL ILLNESS ____
HOSPITAL INDEMNITY _____	LIFE INSURANCE ____
CANCER/STROKE/HEART _____	FINAL EXPENSE ____
HOME HEALTHCARE _____	SHORT TERM CARE ____

SELECT ALL THAT APPLY TO YOU

MARRIED _____	INTERNET USER _____	VETERAN _____
SINGLE _____	SOCIAL MEDIA USER _____	WIDOWED _____

OTHER INTERESTS ____

PLEASE SHARE HOW WE HAVE HELPED YOU ____

MAY WE SHARE YOUR TESTIMONY? ___________

WOULD YOU RECOMMEND OUR SERVICES TO OTHERS? __________

All information is confidential and for office use only.

5/5/2021