

**Individual Health Census**

Date: \_\_\_\_\_

Agent: \_\_\_\_\_

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_ Smoker: Y / N

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

County: \_\_\_\_\_ Occupation: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Spouse: \_\_\_\_\_ Smoker: Y / N Birthdate: \_\_\_\_\_

Children: \_\_\_\_\_ Birthdate: \_\_\_\_\_

\_\_\_\_\_ Birthdate: \_\_\_\_\_

\_\_\_\_\_ Birthdate: \_\_\_\_\_

\_\_\_\_\_ Birthdate: \_\_\_\_\_

**Policy Info:** Current Carrier: \_\_\_\_\_ Deductible: \_\_\_\_\_

**Medical Conditions:**

Diagnosis Date Diagnosed: Medication Dosage

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\_\_\_\_\_

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Carriers Quoted/Comments: \_\_\_\_\_

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