unisource
Insurance Services

A full range of services for our clients

individual benefits form

Date: ______________________

Name: ____

Address: ____

City: ______________________ **State:** __________ **Zip:** ______________________

Phone: ( ) ____________________ **Cell:** ( )___________________________

Email: ______________________________________ **Date of Birth:** _______________

Coverage Options

(**Select all that apply)**

☐ **MEDICAL INSURANCE**

Current Coverage: ______________________________Mo. Premium: $ ______________

Type of Plan Desired: ______ HMO ______ PPO

Dependent Coverage: ◯ Spouse Age: ________

◯ Children Ages: ___________________

◯ Family (Spouse + Children)

☐ **LIFE INSURANCE** Amount of Coverage Desired: $ ____________________

Smoker: ◯ Yes ◯ No

☐ **DISABILITY INSURANCE** Occupation: _________________________________