Greg Dellinger
Independent Agent
405-245-9173
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CLIENT INFORMATION

Date: ______________________ *Effective Date of Policy: ______________________

How did you hear about us: ______________________

Name: ______________________

Physical Address: ______________________

Mailing Address: ______________________

County: ______________________ Email ______________________

Phone: ______________________

SSN: ______________________ DOB: ______________________

Birth State: ______________ Height: ______________ Weight: ______________

Medicare Number: ______________________

Part A Effective Date: ______________________ Part B Effective Date: ______________________

Current Insurance: Part: ❏ A ❏ B ❏ D ❏ Medicare Advantage ❏ Group ❏ VA

Insurance Plan Names: ______________________

Primary Care Physician: ______________________

Pharmacy / Address: ______________________

PRESCRIPTION LIST

DRUG NAME	DOSAGE	GENERIC	BRAND NAME
		❏	❏
		❏	❏
		❏	❏
		❏	❏
		❏	❏
		❏	❏
		❏	❏
		❏	❏

Tobacco Use? ❏ Yes ❏ No

Any major health issues in the past 3 years?

❏ Heart Attack ❏ Diabetes ❏ Stroke ❏ Cancer ❏ Autoimmune

YEARLY INCOME

❏ LIS ❏ Single under 85k ❏ Single over 85k ❏ Combined over 170k

Bank Name: ______________________

Routing: ______________________ Account: ______________________

Payment Method: Part: ❏ Bank Draft ❏ Direct Bill

Payment Method: Part: ❏ Monthly ❏ Quarterly ❏ Semi-Annual ❏ Annual