H2 INSURANCE SERVICES, INC.

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Family Health Fact Finder

Primary Insured Name: _____ Phone #: _____

Address: _____City: _____ Zip: _____

DOB: _____ Sex: M☐ F☐

Do you currently have health insurance? ☐Yes ☐No If yes, with whom:

_____

Type of coverage you are interested in: ☐Health ☐Dental ☐Vision

#	Dependent's Name	Sex	DOB	Relationship
1				
2				
3				
4				
5				
6				
7				

Names of providers/doctors that you would prefer to be in your network:

Any other information/concerns/major health problems: