



# Individual New Business Inquiry

FAX to Underwriting Department (805) 480-8847

## INDIVIDUAL INFORMATION

Name of Applicant			Social Security or ID No.		
No. of Dependents Enrolling	Prior Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No		Occupation		
Agent		Agent ID No.	Date Inquiry Submitted/Faxed	Requested Effective Date	
General Agent			Phone No. ( ) ( )	FAX No. ( ) ( )	
PlanScope® PPO and EPO Plan Choices			HMO Coverage		
<input type="checkbox"/> BC Life Basic PPO 1000 (7900) <input type="checkbox"/> PPO Share 1500 (7889) <input type="checkbox"/> BC Life Basic PPO 1000 Without Life (PE25) <input type="checkbox"/> BC Life PPO Share 5000 (H062) <input type="checkbox"/> PPO Share 1000 (1393) or BC Life Share 1000 (1930) <input type="checkbox"/> BC Life PPO Saver Without Life (PE27) <input type="checkbox"/> BC Life PPO Saver (NM31) <input type="checkbox"/> PPO Share 2500 (7891) <input type="checkbox"/> PPO Share 500 (7895) or BC Life Share 500 (1929) <input type="checkbox"/> EPO (MSA Compatible) (7892)			<input type="checkbox"/> HMO Saver (7896) (available statewide) <input type="checkbox"/> Individual HMO (7898) (available statewide)		

## MEDICAL CONDITIONS

APPLICANT DATA					DEPENDENT DATA				
<input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Height	Weight	Smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Height	Weight	Smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No
Specific Diagnosis and Date of Onset					Specific Diagnosis and Date of Onset				
Date(s) of Treatment					Date(s) of Treatment				
Date of Full Recovery					Date of Full Recovery				
Current Medication(s)/Dosages					Current Medication(s)/Dosages				

## GENERAL CONCERNS AND QUESTIONS


## UNDERWRITING RESPONSE

<input type="checkbox"/> Possible Level I + 20% <input type="checkbox"/> Possible Level I + 50% <input type="checkbox"/> Possible Level I + 75% <input type="checkbox"/> Possible Level I + 100% <input type="checkbox"/> Cannot determine without medical records <input type="checkbox"/> Possible MRMP	Notes:
	Underwriter _____ Underwriter Unit No. _____ Date _____

Indications resulting from this inquiry are preliminary and based solely upon the completeness and accuracy of the information provided, and are subject to change based upon further review and additional information provided or not disclosed. If you are submitting this case, please be sure to include a copy of this inquiry and our response with the completed and signed applications. This response is no guarantee that your application will be approved. **Thank you!**