INDIANA STATE BAR ASSOCIATION
Serving the legal profession and the public

Name:		**Requested Effective Date:**	
Today's Date:		**Address:**	
Phone Number:		**City, State:**	
Email Address:		**Zip Code:**	
Occupation		**County in which you live**	

Family Details	First & Last Name Required	DOB	M/F	Height	Weight	Tobacco User (Y/N)
Primary						
Spouse						
Dependent #1						
Dependent #2						
Dependent #3						
Dependent #4						
Dependent #5						

Medical Profile (past 10 years)

Name of Individual	Diagnosis	Treatment – (counseling, PT, OT etc., follow ups etc.)	Medication – name, dosage	Date(s) of Treatment	Hospitalized? (Y/N)	Surgery? (Y/N)	Recovered? (Y/N)

Current Carrier and Plan Design?	
What would you like your Health Insurance to look like (copays, high/low eductible, HSA)?	
Are you Interested in dental/Vision/ or Maternity Coverage?	
Would you like an Association Term Life Quote? Up to $500k!	

Fax to Individual Health Department: 317-471-1700