



# Pond Insurance Associates

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### Agent Information

Name: Larry L. Pond SS# 456-84-4070

Address: P O Box 569 (1401 Holliday, Ste 310) Wichita Falls TX 76307

Phone: 940-723-4567 Fax: 940-723-4571

If you have any questions please contact: **Carol Hutson**

### Group Information

Name: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Number of Employees to be Insured: \_\_\_\_\_ Workers Comp in force: \_\_\_\_\_ Email Address: \_\_\_\_\_

Nature of Business: \_\_\_\_\_ SIC Code: \_\_\_\_\_

Requested effective Date: \_\_\_\_\_ Renewal Date: \_\_\_\_\_

### Current Coverage Information

Current Carrier: \_\_\_\_\_ Current PPO Network: \_\_\_\_\_

Premiums:	Current	Renewal
Employee	\$ _____	\$ _____
Employee & Spouse	\$ _____	\$ _____
Employee & Child (ren)	\$ _____	\$ _____
Family	\$ _____	\$ _____
Monthly Total Medical Premium	\$ _____	\$ _____

Employer contributes \_\_\_\_\_ percent of the premium for the employee

Employer contributes \_\_\_\_\_ percent of the premium for the dependants

**CURRENT PLAN**

Co-Pay  \$15.00  \$20.00  \$25.00  Other \$ \_\_\_\_\_

Deductible:  \$250/\$500  \$500/\$1,000  \$1,000/\$2,000  Other \$ \_\_\_\_\_

Co-Insurance:  90%/70%  80%/60%  70%/50%  Other \$ \_\_\_\_\_

Co-Insurance:  \$5000  \$10,000  Other \$ \_\_\_\_\_

Separate drug deductible:  Yes  No

If yes, deductible level:  \$50  \$100  \$150  Other \$ \_\_\_\_\_

Drug Card  No  Yes  \$15 generic/\$25 name brand/\$40 nonpreferred  
 \$10 generic/\$15 name brand/\$30 nonpreferred  
 \$\_\_\_\_ generic/\$\_\_\_\_ name brand/\$\_\_\_\_nonpref

**REQUESTED PLAN OPTIONS**

Co-Pay  \$15.00  \$20.00  \$25.00  Other \$ \_\_\_\_\_

Deductible  \$250/\$500  \$500/\$1,000  \$1,000/\$2,000  Other \$ \_\_\_\_\_

Co-Insurance  90%/70%  80%/60%  70%/50%  Other \$ \_\_\_\_\_

Co-Insurance limit  \$5,000  \$10,000  Other \$ \_\_\_\_\_

Drug Card  No  Yes  \$15 generic/\$25 name brand/\$40 nonpreferred  
 \$10 generic/\$15 name brand/\$30 nonpreferred

Policy Life Time Max \_\_\_\_\_  \$\_\_\_\_ generic/\$\_\_\_\_ name brand/\$\_\_\_\_nonpref

**Optional Benefits**

Life Insurance If yes, amount:  \$10,000  \$15,000  \$20,000  \$25,000

Accident Supplement  Preventive/ Well Care  24 Hour Coverage  Other \_\_\_\_\_

Vision  Maternity  Dental  Cancer Plan  Long-Term Disability

Short-term disability  COBRA Administration  125 Premium Savings (POP)

	<b>Employer Name:</b>					
	<b>NAME OF EMPLOYEE</b>	<b>EMPLOYEE CENSUS</b>				Date:
		<b>DOB</b>	<b>AGE</b>	<b>SEX M/F</b>	<b>*E; E/S E/C;FAM</b>	<b>Pre-Exist Conditions</b>
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\*E = Employee Only Coverage E/S = Employee & Spouse E/C = Employee & Child(ren) FAM = Family



# Pond Insurance Associates

Print Full Name: Applicant \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Spouse \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Number of dependent children to be covered \_\_\_\_\_

Home City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## Health Statement for the Employee and Dependents

You must answer all questions for **yourself and all dependents** requesting coverage (one form per family)

Please **provide details to all "YES" answers below.**

Has any applicant had, been medically advised of having, been treated for (including medications) or been referred for treatment, advice or hospitalization for any of the following within the past five (5) years?

1. Any disorder/disease of the heart, lungs, liver, pancreas, colon, back, bones, brain, central nervous system muscles or joints?  Yes  No **Name and dosage of all medications being taken**

2. Any disorder/disease of the digestive system, urinary tract, kidneys, reproductive system or infertility?  Yes  No **Name and dosage of all medications being taken**

3. Any immune system disorder, AIDS, ARC, positive HIV, or chronic lung disorder?  Yes  No **Name and dosage of all medications being taken**

4. Stroke, paralysis, leukemia, cancer, tumors, neurological or seizure disorder, arthritis, or birth defect?  Yes  No **Name and dosage of all medications being taken**

5. Any mental, nervous, or behavioral disorder, chemical imbalance, alcoholism or drug abuse addiction?  Yes  No **Name and dosage of all medications being taken**

6. Diabetes?  Yes  No **Name and dosage of all medications being taken**  
If YES, last blood sugar reading and date:

7. High blood pressure?  Yes  No **Name and dosage of all medications being taken**  
If YES, last 3 blood pressure readings and dates:

8. In the past three years has the applicant or dependent had medical expenses or claims expenses or claims of \$ 5,000 or more?  Yes  No If YES, **provide details.**

9. Is the employee or dependent pregnant?  Yes  No  
If YES, Name: \_\_\_\_\_ Anticipated Due Date: \_\_\_\_\_

10. Please list any medications or treatments not list above **including names, dates, diagnosis and dosage.**

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Male Female (check one)

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**By signing this form I authorize Pond Insurance Associates and my employe r to release this medical information to any insurance company deemed necessary to obtain insurance quotes for my employer.**