

Please, feel free to contact us if you have any questions. Thank You!

the **SOLINSKY**
FINANCIAL GROUP INC

Please, complete these forms, and return them to us via FAX, E-mail or USPS. Thank You!

Phone: 520.885.6623

Group Quote Request

FAX: 520.203.0216

Group Information	Broker Information
Name	Phil Solinsky
Address	11240 East Calle Vaqueros
Address	Tucson, Arizona 85749
City St Zip	phil@solinsky-inc.com

Requested Benefits

Medical				Out of Pocket		Dental		Ancillary			
Plan	Deductible					Plan	Group		Voluntary		
HMO <input type="checkbox"/>	500	<input type="checkbox"/>	2500	<input type="checkbox"/>	5,000	<input type="checkbox"/>	Indemnity	<input type="checkbox"/>	Vision	<input type="checkbox"/>	<input type="checkbox"/>
PPO <input type="checkbox"/>	1000	<input type="checkbox"/>	3000	<input type="checkbox"/>	10,000	<input type="checkbox"/>	PPO	<input type="checkbox"/>	STD	<input type="checkbox"/>	<input type="checkbox"/>
POS <input type="checkbox"/>	1500	<input type="checkbox"/>	5000	<input type="checkbox"/>			DMO	<input type="checkbox"/>	LTD	<input type="checkbox"/>	<input type="checkbox"/>
MSA <input type="checkbox"/>	2000	<input type="checkbox"/>	HSA	<input type="checkbox"/>			Voluntary	<input type="checkbox"/>	Life \$	<input type="checkbox"/>	<input type="checkbox"/>

Specific Carriers Requested:

Current Information

Number of Employees	Employer Contribution %	Renewal Date	Employees in
Total	EE	Current	Arizona <input type="checkbox"/>
Eligible	Dependents	Desired	Out of State <input type="checkbox"/>
Participating			# of Locations _____
Cobra (on census)	Nature of Business	SIC Code	Yrs in Business
Carve Out	Y N	Current Carrier	Yrs with Carrier
Waiting Period		Previous Carrier	Yrs with Carrier

Current Rates	Medical				Dental		Vision		Other	
	HMO		PPO/POS/HSA		Current	Renewal	Current	Renewal	Current	Renewal
	Current	Renewal	Current	Renewal						
EE										
EE/SP										
EE/CH										
EE/SP/CH										

Current Benefits	Medical		Dental		Ancillary	
	HMO	PPO/POS				
Phys Co-Pay			Deductible		Life/AD&D	<input type="checkbox"/>
Deductible			Plan Design		Amount \$	
Co Ins			Calendar Yr Max		Dep Life	<input type="checkbox"/>
OOP Max			Ortho Included		Vision	<input type="checkbox"/>
Family Max					STD	<input type="checkbox"/>
RX Co-pay					LTD	<input type="checkbox"/>
Hosp Co-pay					Sec 125	<input type="checkbox"/>

If you are aware of any employee's in your group who has one of the conditions listed below, please mark accordingly.

Arthritis <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Kidney Disorder <input type="checkbox"/>	Open Hrt Surg <input type="checkbox"/>	Alcohol or Drug Abuse <input type="checkbox"/>
Back/Neck <input type="checkbox"/>	Epilepsy <input type="checkbox"/>	Lung Disorder <input type="checkbox"/>	Organ Transplt <input type="checkbox"/>	Other: _____ <input type="checkbox"/>
Cancer <input type="checkbox"/>	Heart Disorder <input type="checkbox"/>	Lupus <input type="checkbox"/>	Pregnancies <input type="checkbox"/>	Other: _____ <input type="checkbox"/>
Cardiac Tests <input type="checkbox"/>	HIV/AIDS <input type="checkbox"/>	MD <input type="checkbox"/>	Psych Disorder <input type="checkbox"/>	Other: _____ <input type="checkbox"/>
Crohns Disease <input type="checkbox"/>	Hypertension <input type="checkbox"/>	MS <input type="checkbox"/>	Stroke <input type="checkbox"/>	Other: _____ <input type="checkbox"/>

IN ADDITION, each employee and dependent enrolling for health coverage including those continuing on COBRA should complete a health history form

COMMENTS:

The Solinsky Financial Group, Inc.

Census

	Gender (M) or (F)	DOB	Coverage Requested					Spouse Age	# of CH	Home Zip Code	Occupation	Monthly Salary	On COBRA
			EE only	EE + SP	EE + CH	EE + FM	WV*						
1													
2													
3													
4													
5													
6													
7													
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*WV = Eligible employees who are waiving coverage

**NC = Not eligible for coverage (i.e. part time or waiting for enrollment)

Employee and Family Medical Questionnaire

Section 1: Employer/Employee Information

Employer Name: _____

Names of Family Members Applying for Coverage	Relationship	Date of Birth	Gender Male/Female	Height	Weight
	Employee				
	Spouse				
	Dependent				
	Dependent				
	Dependent				

Section 2: Family Health History

Within the past five (5) years has a physician or other licensed healthcare practitioner ("practitioner") diagnosed or treated you or anyone in your family applying for coverage, or is anyone currently getting treatment? Use an "X" to mark "YES" or "NO" in the boxes heading each category of conditions below and mark with an "X" any of the following conditions that apply.

For all "YES" answers and conditions that you mark with an "X", provide details in the table on the next page.

A. Heart/Circulatory <input type="checkbox"/> YES <input type="checkbox"/> NO	D. Cancer/Tumors <input type="checkbox"/> YES <input type="checkbox"/> NO	H. Bones/Muscles/Joints <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> A1. Anemia <input type="checkbox"/> A2. Angina <input type="checkbox"/> A3. Angioplasty/Stent <input type="checkbox"/> A4. Aneurysm <input type="checkbox"/> A5. Blood Clots <input type="checkbox"/> A6. Blood Disorder <input type="checkbox"/> A7. Bypass <input type="checkbox"/> A8. Cardiac Arrhythmia <input type="checkbox"/> A9. Chest Pain <input type="checkbox"/> A10. Congestive Heart Failure <input type="checkbox"/> A11. Coronary Heart Disease <input type="checkbox"/> A12. Heart Murmur <input type="checkbox"/> A13. Hemophilia <input type="checkbox"/> A14. High/Low Blood Pressure <input type="checkbox"/> A15. High Cholesterol <input type="checkbox"/> A16. Pacemaker <input type="checkbox"/> A17. Palpitations <input type="checkbox"/> A18. Sickle Cell Anemia <input type="checkbox"/> A19. Stroke/TIA <input type="checkbox"/> A20. Varicose Veins <input type="checkbox"/> A21. Ventricular Tachycardia <input type="checkbox"/> A22. Other (_____)	<input type="checkbox"/> D1. Brain <input type="checkbox"/> D2. Breast <input type="checkbox"/> D3. Colon <input type="checkbox"/> D4. Cyst <input type="checkbox"/> D5. Hodgkin's Disease <input type="checkbox"/> D6. Leukemia <input type="checkbox"/> D7. Liver <input type="checkbox"/> D8. Lung <input type="checkbox"/> D9. Lymphoma <input type="checkbox"/> D10. Melanoma <input type="checkbox"/> D11. Ovarian <input type="checkbox"/> D12. Pituitary <input type="checkbox"/> D13. Prostate <input type="checkbox"/> D14. Stomach <input type="checkbox"/> D15. Testicular <input type="checkbox"/> D16. Thyroid <input type="checkbox"/> D17. Other (_____) <input type="checkbox"/> D18. Stage of Cancer if known _____	<input type="checkbox"/> H1. Bulging/Herniated Disk <input type="checkbox"/> H2. Carpal Tunnel Syndrome <input type="checkbox"/> H3. Fibromyalgia/CFS <input type="checkbox"/> H4. Fractures (Open or Closed) <input type="checkbox"/> H5. Gout <input type="checkbox"/> H6. Joint Replacement (Type: _____) <input type="checkbox"/> H7. Knee <input type="checkbox"/> H8. Muscular Dystrophy <input type="checkbox"/> H9. Neck/Back <input type="checkbox"/> H10. Shoulder <input type="checkbox"/> H11. Spina Bifida <input type="checkbox"/> H12. Sprain/Strain <input type="checkbox"/> H13. Other (_____)
B. Eyes/Ears/Nose/Throat <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> B1. Acoustic Neuroma <input type="checkbox"/> B2. Cataracts <input type="checkbox"/> B3. Chronic Sinusitis <input type="checkbox"/> B4. Cleft Lip/Palate <input type="checkbox"/> B5. Detached Retina <input type="checkbox"/> B6. Deviated Septum <input type="checkbox"/> B7. Ear Infections <input type="checkbox"/> B8. Glaucoma <input type="checkbox"/> B9. Retinopathy <input type="checkbox"/> B10. Other (_____)	E. Neurological <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> E1. Alzheimer's Disease <input type="checkbox"/> E2. Cerebral Palsy <input type="checkbox"/> E3. Epilepsy <input type="checkbox"/> E4. Head Injury <input type="checkbox"/> E5. Migraines <input type="checkbox"/> E6. Multiple Sclerosis <input type="checkbox"/> E7. Neuritis <input type="checkbox"/> E8. Paralysis/Hemiplegia <input type="checkbox"/> E9. Parkinson's Disease <input type="checkbox"/> E10. Seizures/Convulsions <input type="checkbox"/> E11. Other (_____)	I. Psychological <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> I1. ADD/ADHD <input type="checkbox"/> I2. Alcoholism <input type="checkbox"/> I3. Anxiety <input type="checkbox"/> I4. Autism <input type="checkbox"/> I5. Bipolar <input type="checkbox"/> I6. Depression <input type="checkbox"/> I7. Drug Abuse <input type="checkbox"/> I8. Eating Disorder <input type="checkbox"/> I9. Schizophrenia <input type="checkbox"/> I10. Suicide Attempt <input type="checkbox"/> I11. Other (_____)
C. Immune <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> C1. ALS <input type="checkbox"/> C2. AIDS <input type="checkbox"/> C3. HIV+ <input type="checkbox"/> C4. Immuno Deficiency <input type="checkbox"/> C5. Lupus <input type="checkbox"/> C6. Psoriasis <input type="checkbox"/> C7. Scleroderma <input type="checkbox"/> C8. Other (_____)	F. Transplants <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> F1. Pending <input type="checkbox"/> F2. On Waiting List <input type="checkbox"/> F3. Completed Transplant <input type="checkbox"/> F4. Bone Marrow <input type="checkbox"/> F5. Stem Cell <input type="checkbox"/> F6. Organ (Type: _____)	J. Diabetes/Endocrine <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> J1. Diabetes controlled by: <input type="checkbox"/> a. Diet <input type="checkbox"/> b. Oral Medication <input type="checkbox"/> c. Insulin <input type="checkbox"/> d. Other (_____) <input type="checkbox"/> J2. Adrenal Glands <input type="checkbox"/> J3. Growth Hormones <input type="checkbox"/> J4. Hyperthyroidism/Hypothyroidism <input type="checkbox"/> J5. Other (_____)
	G. Arthritis <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> G1. Arthritis <input type="checkbox"/> G2. Osteoarthritis <input type="checkbox"/> G3. Rheumatoid Arthritis <input type="checkbox"/> G4. Other (_____)	K. Reproductive <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> K1. Breast Disorder <input type="checkbox"/> K2. Endometriosis <input type="checkbox"/> K3. Fibroids <input type="checkbox"/> K4. Menstrual Disorder <input type="checkbox"/> K5. Ovarian Cysts <input type="checkbox"/> K6. Other (_____)

L. Lung/Respiratory	<input type="checkbox"/> YES <input type="checkbox"/> NO	M. Intestinal	<input type="checkbox"/> YES <input type="checkbox"/> NO	N. Liver/Kidney/Urinary	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> L1. Allergies		<input type="checkbox"/> M1. Acid Reflux/GERD		<input type="checkbox"/> N1. Bladder Disorder	
<input type="checkbox"/> L2. Asthma		<input type="checkbox"/> M2. Colitis/IBS		<input type="checkbox"/> N2. Cirrhosis	
<input type="checkbox"/> L3. COPD (On Oxygen? _____)		<input type="checkbox"/> M3. Colon Disorder		<input type="checkbox"/> N3. Gaucher's Disease	
<input type="checkbox"/> L4. Cystic Fibrosis		<input type="checkbox"/> M4. Crohn's Disease		<input type="checkbox"/> N4. Hepatitis (Type: _____)	
<input type="checkbox"/> L5. Emphysema		<input type="checkbox"/> M5. Diverticulitis/Diverticulum		<input type="checkbox"/> N5. Jaundice	
<input type="checkbox"/> L6. Lung Disorder		<input type="checkbox"/> M6. Gallbladder		<input type="checkbox"/> N6. Kidney Disorder	
<input type="checkbox"/> L7. Pneumonia		<input type="checkbox"/> M7. Gastric Bypass		<input type="checkbox"/> N7. Kidney Stones	
<input type="checkbox"/> L8. Sarcoidosis		<input type="checkbox"/> M8. Hiatal Hernia/Reflux		<input type="checkbox"/> N8. Liver Disorder	
<input type="checkbox"/> L9. Sleep Apnea		<input type="checkbox"/> M9. Pancreatitis		<input type="checkbox"/> N9. Polycystic Kidney	
<input type="checkbox"/> L10. Tuberculosis		<input type="checkbox"/> M10. Ulcer		<input type="checkbox"/> N10. Prostate	
<input type="checkbox"/> L11. Valley Fever		<input type="checkbox"/> M11. Ulcerative Colitis		<input type="checkbox"/> N11. Renal Failure	
<input type="checkbox"/> L12. Other (_____)		<input type="checkbox"/> M12. Other (_____)		<input type="checkbox"/> N12. Other (_____)	

Please answer the following questions for yourself and for anyone in your family applying for coverage:

- YES NO Is anyone currently pregnant or an expectant parent?
Due date: _____
 Yes No a. Has the pregnancy been confirmed by a physician or practitioner?
 Yes No b. Pregnancy complications?
 Yes No c. Multiple births expected?
- YES NO Is anyone currently, or in the past five years has anyone been, a patient in a hospital, clinic, surgi-center, urgent care facility, or other medical facility as an inpatient or outpatient?
- YES NO Does anyone currently use tobacco products, including cigarettes, pipes, cigars or chewing tobacco?
- YES NO Does anyone currently have, or in the past 12 months has anyone had, any of the following?
 abnormal test or physical results pending test results
 health condition, illness or injury that may require treatment or surgery
 tests, treatment or surgery advised unexplained weight gain/loss or fatigue
 Worker's Compensation injury or illness condition not mentioned above in Section 2

Please use this table to explain any "YES" answers or items that you marked in Section 2. You may attach additional sheets.

Question Number	Name	Diagnosis/Treatment	Diagnosis Date	Treatment Status

Section 3: Family Medications

YES NO Are you or anyone in your family applying for coverage currently taking any medications (including "over the counter" or "OTC" medicine) prescribed or recommended by a physician or practitioner?

If you answer "YES" to the question above, please use this table to explain. You may attach additional sheets.

Name	Medicine	Dosage & Frequency of Use	Date Prescribed	Date Last Taken or Ongoing	Condition(s) Being Taken For

PLEASE NOTE: If you leave out or misrepresent any information, the premium for your group coverage may change retroactive to the date the policy became effective. You or your authorized agent is entitled to receive a copy of this form.

Employee Signature: _____

Date Signed: _____