



Benefit Review Services inc.

Personal Insurance Solutions

PREQUALIFICATION APPLICATION

Name: _____ DOB: ____/____/____ Height _____ Weight _____

Address: _____ City: _____

County: _____ State: _____ Zip Code: _____

Contact Phone Number: _____ Email Address: _____

Please enter in all immediate family members regardless of whether they are electing coverage:

Spouse: Date of Birth: ____/____/____ Height: _____ Weight: _____ Gender: Male Female

Child 1: Date of Birth: ____/____/____ Height: _____ Weight: _____ Gender: Male Female

Child 2: Date of Birth: ____/____/____ Height: _____ Weight: _____ Gender: Male Female

Child 3: Date of Birth: ____/____/____ Height: _____ Weight: _____ Gender: Male Female

Please answer the following questions:

1. Are all individuals applying for coverage United States citizens? Yes No

2. Does any applicant use any form of tobacco (cigarettes, chewing tobacco, etc.)? Yes No
a. If "Yes" please list the applicants who use tobacco _____

3. What is your estimated 2017 **household** income? It is important to be as accurate as possible. This number will be used for subsidy determination. _____

4. What is the name of your current employer? _____

6. Has your employer offered you group health insurance? Yes No

7. How did you hear about us? _____

8. Which insurance products you would like to review?

Medical

Dental

Vision

Life

Disability

Other

NOTE: All information submitted by prospective clients will be kept in strict confidence per the HIPPA regulations and all applicable insurance institution privacy laws.

43370 Mound Road Sterling Heights, MI 48317

Toll Free (855) 997-9700 | Phone (586) 997-9966 | Fax (586) 997-9968

www.brsipersonal.com | info@brsipersonal.com