

## HEALTH INSURANCE QUOTE REQUEST FORM

Name: \_\_\_\_\_ M/F \_\_ : DOB: \_\_\_\_ Tobacco Use Y/N

Spouse / Partner: \_\_\_\_\_ M/F \_\_ : DOB: \_\_\_\_ Tobacco Use Y/N

Children: Y / N      Ages : \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_ Best Time to Contact \_\_\_\_\_

Seeking Insurance: \_\_\_\_ As soon as possible; \_\_\_\_ With in a few months; \_\_\_\_ Not Sure

Notes:

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Return this form with your application by fax to 208-535-2272 or mail to address below :



**VM ENTERPRISES LLC**  
INSURANCE SERVICES

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