



**MEDICAL
MUTUAL
OF OHIO.**



Quote Request Form

Broker Name _____ Sales Rep _____

Effective Date _____ County _____ Zip _____

Applicant:

Spouse:

Full Name _____

Full Name _____

M F Date of Birth _____

M F Date of Birth _____

Height _____ Weight _____

Height _____ Weight _____

Tobacco Use? Y N

Tobacco Use? Y N

DEPENDENTS: (if a dependent is a tobacco user please note "TU" next to their information)

M F dob _____ ht/wt _____ M F dob _____ ht/wt _____

M F dob _____ ht/wt _____ M F dob _____ ht/wt _____

M F dob _____ ht/wt _____ M F dob _____ ht/wt _____

Please list any known medical conditions and medications FOR EACH FAMILY MEMBER for the last 6 years.

Applicant	Specific Diagnosis & Treatment Details	Duration of Condition		Medication Name, Dosage & Frequency	Dates of use	
		Begin	End		Begin	End

Products

90% Standard Plan	750	1500	High Deductible Plan	2000	4000
80% Standard Plan	750	1500	2500 Wellness HSA (80/20)	1200	2400
Value Plan	750	1500	2500 Wellness HSA (100)	3500	5000

NOTE: Final rates will be based upon the actual location, enrolled individuals and underwriting rules in effect upon acceptance by the insurance carrier. This proposal is subject to underwriting approval by the insurance carrier.

**PLEASE FAX QUOTE REQUEST TO 614-863-0205
Dodd Brokerage Phone (614) 863-3633 (800) 862-0085**

