Membership Benefit Alert!

Receive Enhanced Insurance Benefits for Yourself, Your Family for Both Full & Part-Time Employees!

Guarantee Issue Accident Coverage

Dental & Vision

Disability Income

Critical Illness

Long-Term Care Insurance

Home Health Care

Assisted Living

Nursing Home Care

Health Insurance

Individuals & Families

Groups

Student Health Plans

Medicare Supplements & Part D

International Travel Insurance

Health Savings Accounts (HSAs)

Individuals/Groups

Life Insurance

Term 5, 10, 20, 25, 30, Age 95

Universal Life

Survivorship (2nd to Die)

Key Person

Executive Benefit Life

Retirement & Financial Services

Annuities

SAVE UP TO 40%

On Insurance Premiums!

Rates and availability may vary by state, based on medical eligibility and compared with current insurance coverage

IALA Association Health Programs
12721 Metcalf Ave Ste 100, Overland Park KS 66213
Phone: (913) 341-2868 Toll Free: (888) 450-3040 Fax: (913) 341-2803
Email: help@associationpros.com
Website: www.associationpros.com

Italian American Lawyers Association

Association Health Programs
Proposal Request

____ Health ____ Long-Term Care ____ Dental/Vision ____ Other

____ Life ____ Disability Income/Critical Illness ____ Accident Coverage

Member Information

Name: ____________________

Address: ____________________

City: ____________________ State: __________ Zip: ____________

Phone Number: ____________________ County: ____________________

Fax Number: ____________________ Email Address: ____________________

Current Coverage:

Company: ____________________ Monthly Premium: ____________

Deductible: ____________________ Copay: ____________ Rx: ____________

How do you feel about your current plan?

____

(Too much, Too much for the plan you have, etc)

What are you looking for in a new plan?

____

(Price, Coverage, Catastrophic, etc)

When are you looking to have new insurance set in place? ____________________

Insured Information:

Date of Birth: ____________ Age: ______

Gender: M / F Tobacco User: Y / N

Height: ____________ Weight: ____________

Occupation: ____________________

Spouse Information

Date of Birth: ____________ Age: ______

Gender: M / F Tobacco User: Y / N

Height: ____________ Weight: ____________

Occupation: ____________________

Children: DOB: __________ M / F DOB: __________ M / F DOB: __________ M / F
DOB: __________ M / F DOB: __________ M / F DOB: __________ M / F

In the Past 5 Years Has Any Insured:

No Yes Taken any prescription medications on a regular basis?
Who/What/Why/When/Dosage: ____________________

____

____

No Yes Been diagnosed or treated for Cancer, Heart Problems, Stroke, Diabetes, High Blood Pressure, Cholesterol, or Any Other Medical Condition:
Who/What/When/Treatment: ____________________

____

____

No Yes Is any insured or spouse or child pregnant? **Due:** ____________

I release the information on this form to be used strictly for obtaining health insurance quotes for myself or my company and understand it will not be shared with any other entity.
Member Signature Required: ____________________