



Dear Prospective Insured,

Thank you for visiting my website. I appreciate the time you have taken to look for a health insurance solution with us. By using the thorough way, you can be assured of the best health insurance solution possible for your situation.

The attached questionnaire will assist my staff in finding the proper health insurance solution for you. Please take the time to thoughtfully fill out the form so we can shop for the best company and plan for you.

Your information will be handled in the strictest confidence. The information requested is necessary so I can speak to underwriters on your behalf. This will allow me to find the best health insurance solution for you. *If you are concerned about identity theft, please substitute your age where date of birth is requested.*

During the next few days, I will work closely with you so we can come to a favorable conclusion for you. In addition, I will continue to stay in touch during your coverage period and to be available to answer any questions you may have regarding the policy you decide to purchase.

There is no cost or obligation for this service.

Regards,

Christopher D. Colvin
Risk Assessment Specialist

Christopher D. Colvin
Independent Broker
2165 Hoodoo Drive – Colorado Springs, CO 80919
phone: 719.472.6669 toll free: 1.866.HSA.MONY (866.472.6669)

Christopher D. Colvin
Independent Broker
Individual Health Insurance Request
phone: 719.472.6669 toll free: 1.866.HSA.MONY (866.472.6669)

*Requesting Agent _____ Date of Request: _____

*Individual Name _____

*Street Address _____

*City, State _____ Zip Code: _____ *Phone _____

email address (we will not disclose to third parties): _____

Your Information: (* indicates a required field)

*DOB ___/___/_____ *Tobacco? yes no Gender _____

*Would you like maternity coverage for you or your spouse? yes no

*Height _____ *Weight _____

Spousal Information:

*Spouse's Name _____ *DOB ___/___/_____

*Tobacco? yes no Gender _____

*Height _____ *Weight _____

| | |
|-----------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|
| Child 1 *Name _____ *DOB ___/___/_____ *Student Y N *Tobacco? Y N Gender _____ | Child 2 *Name _____ *DOB ___/___/_____ *Student Y N *Tobacco? Y N Gender _____ |
| Child 3 *Name _____ *DOB ___/___/_____ *Student Y N *Tobacco? Y N Gender _____ | Child 4 *Name _____ *DOB ___/___/_____ *Student Y N *Tobacco? Y N Gender _____ |

Current Carrier _____ Renewal Date _____

Monthly Premium _____ Deductible _____

Co-insurance _____ Copay _____ HSA yes no

Current Coverage: Individual Group None

Maternity Accident Life Dental Vision

LTD (long term disability) STD (short term disability)

*Pre-existing Conditions (please indicate which prospective insured these apply to):

Prescription _____ Dosage _____ Freq _____ Reason _____ Who _____

Prescription _____ Dosage _____ Freq _____ Reason _____ Who _____

Prescription _____ Dosage _____ Freq _____ Reason _____ Who _____

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Individual Health Insurance Request
phone: 719.472.6669 toll free: 1.866.HSA.MONY (866.472.6669)

What do you absolutely not want in your health insurance policy? _____

Is there anything else in your health history not asked above you believe an insurance company may question during the underwriting period?

Is it important to keep your same doctors, specialists or hospital provider? Yes No

If yes, please list your doctor's names, addresses and phone numbers I can be sure I make a notation as I'm performing the search:

How did you find out about us?

Would you be interested in a life insurance quote or policy review? Yes No If so, how much?

Thank you for taking the time to fill out this Individual Health Insurance Request. Using this information, we will check with our carriers to see who would be the best fit for you. We will fax or mail you the names of the carriers and their quotes then follow up with a phone call to discuss which carrier you would like to go with.

Please note, I am not an advocate of choosing a policy based on cost alone. I have known individuals who have purchased policies based on a radio advertisement with a toll free number, or off the internet. When they had a major medical issue, the company did not pay the claim and fell back on the fine print of the contract to reject the claim. Unlike internet shopping where it is possible to find discounts on items like books, electronics, etc., there are no discounts available for health insurance in the state of Colorado. All premiums charged in Colorado are registered and regulated by the state. Shopping for and ordering health insurance over the internet would be like taking your car to an auto repair place, having access to the entire mechanic's tool kit, repairing the car yourself, and still having to pay the full repair price as if the mechanic worked on the repair himself. Please allow me to be your risk manager. You will have adequate coverage at an affordable premium.

All premiums are paid directly to the insurance carrier. I cannot accept cash or any checks made out to someone other than the insurance carrier directly. All policies come with a money back guarantee. Examine your policy. If you don't like it, return it within 20 days for a full refund of your premium.

Please mail your request to: Christopher Colvin
2165 Hoodoo Dr.
Colorado Springs, CO 80919

Or FAX to: 719-884-1254

Or email to: cdcolvin@springshealthplans.com

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 Please review the following medical conditions and check any that you or any person applying for coverage were diagnosed with, received treatment for, or consulted a health care provider for in the past 10 years. These conditions may be associated with the specific medical category under which they're listed. However, they are examples of the medical category and do not necessarily include all the conditions related to that category. Therefore, if you have a particular illness or condition which does not appear on the list or you are uncertain which category it's associated with, please describe on a separate sheet of paper. Please be sure to explain the outcome of each item described below including dates you were cleared of any conditions and describe any ongoing treatments of conditions currently existing

Driving Record

- Any adverse driving history: _____
 Date(s): _____
 DUI/DWI (past 5 years) _____
 Reckless Driving _____
 Moving Violations _____
 (past 2 years) _____

Hazardous Activity

- Participation in any hazardous activity during the past 5 years:**
 Automobile Racing Ultralight Flying
 Skydiving Powerboat Racing
 Hang Gliding Scuba Diving
 Motorcycle Racing Other _____

Medical Conditions List

| Condition | Date Cond. Began | Person Being Treated/Treatment Provided |
|---------------------------------------------------------------|------------------|-----------------------------------------|
| <input type="checkbox"/> Complications of Pregnancy | | |
| <input type="checkbox"/> Ectopic Pregnancy | | |
| <input type="checkbox"/> Gestational Diabetes | | |
| <input type="checkbox"/> Miscarriage | | |
| <input type="checkbox"/> Pre-term Labor | | |
| <input type="checkbox"/> Pre-eclampsia | | |
| <input type="checkbox"/> C-Section | | |
| Other _____ | | |
| <input type="checkbox"/> Pap Smear | | |
| <input type="checkbox"/> Cervical Dysplasia | | |
| <input type="checkbox"/> Inflammation | | |
| <input type="checkbox"/> Cervicitis | | |
| <input type="checkbox"/> Cervical Cancer | | |
| <input type="checkbox"/> Atypical Squamous Cells (ASCUS) | | |
| Other _____ | | |
| <input type="checkbox"/> Reproductive System Disorders | | |
| <input type="checkbox"/> Sexually Transmitted Disease (STDs) | | |
| <input type="checkbox"/> Infertility | | |
| <input type="checkbox"/> Ovaries | | |
| <input type="checkbox"/> Endometriosis | | |
| <input type="checkbox"/> Rectocele | | |
| <input type="checkbox"/> PMS | | |
| <input type="checkbox"/> Cervix | | |
| <input type="checkbox"/> Irregular Menses | | |
| <input type="checkbox"/> Ovarian Cyst | | |
| <input type="checkbox"/> Cystocele | | |
| <input type="checkbox"/> Polycystic Ovarian Disease | | |
| <input type="checkbox"/> Vagina | | |
| <input type="checkbox"/> Uterus | | |
| <input type="checkbox"/> Uterine Fibroids | | |
| <input type="checkbox"/> Prolapsed Uterus | | |
| <input type="checkbox"/> Penis | | |
| <input type="checkbox"/> Testes | | |
| Other _____ | | |

Medical Conditions List *(continued)*

| Condition | Date Cond. Began | Person Being Treated/Treatment Provided |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------|
| Heart/Circulatory | | |
| <input type="checkbox"/> High Blood Pressure | | |
| <input type="checkbox"/> Heart Attack | | |
| <input type="checkbox"/> Heart Disease or Defect | | |
| <input type="checkbox"/> Stroke or TIA | | |
| <input type="checkbox"/> Chest Pain | | |
| <input type="checkbox"/> Varicose Veins | | |
| <input type="checkbox"/> Phlebitis | | |
| <input type="checkbox"/> Heart Murmur | | |
| <input type="checkbox"/> Mitral Valve Prolapse | | |
| <input type="checkbox"/> Elevated Cholesterol or Triglycerides | | |
| <input type="checkbox"/> Peripheral Vascular | | |
| <input type="checkbox"/> Disease | | |
| <input type="checkbox"/> Irregular Heart Beat | | |
| <input type="checkbox"/> Other _____ | | |
| <i>Please provide the most current date and reading for blood pressure, cholesterol and triglycerides (including HDL, LDL and total cholesterol).</i> | | |
| Blood Pressure _____ | | |
| Cholesterol HDL: _____ | | |
| LDL: _____ | | |
| Triglycerides _____ | | |
| Immune Deficiency | | |
| <input type="checkbox"/> Swollen Lymph Nodes | | |
| <input type="checkbox"/> Chronic Fatigue | | |
| <input type="checkbox"/> Skin Rashes | | |
| <input type="checkbox"/> Depression | | |
| <input type="checkbox"/> Loss of Appetite | | |
| <input type="checkbox"/> Fever | | |
| <input type="checkbox"/> Unexplained Infections | | |
| <input type="checkbox"/> Pneumonia | | |
| <input type="checkbox"/> Weight Loss | | |
| <input type="checkbox"/> Oral Thrush | | |
| Blood/Lymph/Anemia | | |
| <input type="checkbox"/> Anemia (type) | | |
| <input type="checkbox"/> Swollen Lymph Nodes | | |
| <input type="checkbox"/> Lymphadenopathy | | |
| <input type="checkbox"/> Chronic Fatigue Syndrome | | |
| Digestive Disorders | | |
| <input type="checkbox"/> Ulcer/Intestinal Disorder | | |
| <input type="checkbox"/> Crohn's | | |
| <input type="checkbox"/> Hemorrhoids or Polyps | | |
| <input type="checkbox"/> Spleen Disorder | | |
| <input type="checkbox"/> GERD | | |
| <input type="checkbox"/> Gastritis | | |
| <input type="checkbox"/> Colitis | | |
| <input type="checkbox"/> Ulcerative Colitis | | |
| <input type="checkbox"/> Hernia | | |
| <input type="checkbox"/> Liver Disorder | | |
| <input type="checkbox"/> Jaundice | | |
| <input type="checkbox"/> Stomach | | |
| <input type="checkbox"/> Gallbladder | | |

Medical Conditions List *(continued)*

| Condition | Date Cond. Began | Person Being Treated/Treatment Provided |
|-------------------------------------------------------------------|------------------|-----------------------------------------|
| <input type="checkbox"/> Irritable Bowel Syndrome | | |
| <input type="checkbox"/> Pancreas Disorder | | |
| <input type="checkbox"/> Hepatitis | | |
| <input type="checkbox"/> Cirrhosis | | |
| <input type="checkbox"/> Diverticulitis or Diverticulosis | | |
| <input type="checkbox"/> Other _____ | | |
| Genitourinary System Disorders | | |
| <input type="checkbox"/> Kidney Stones | | |
| <input type="checkbox"/> Prostate Disorder | | |
| <input type="checkbox"/> Kidney Disorder | | |
| <input type="checkbox"/> Cystitis | | |
| <input type="checkbox"/> Glomerulonephritis | | |
| <input type="checkbox"/> Bladder Infections | | |
| <input type="checkbox"/> Nephritis | | |
| <input type="checkbox"/> Other _____ | | |
| Bone/Muscle/Connective Tissue Disorders | | |
| <input type="checkbox"/> Arthritis or Rheumatism | | |
| <input type="checkbox"/> Low Back Pain | | |
| <input type="checkbox"/> ACL Tear | | |
| <input type="checkbox"/> Back/Spine Disorder | | |
| <input type="checkbox"/> Scoliosis | | |
| <input type="checkbox"/> Bursitis/Tendonitis | | |
| <input type="checkbox"/> Gout | | |
| <input type="checkbox"/> Fractures | | |
| <input type="checkbox"/> Spinal Fusion | | |
| <input type="checkbox"/> Manipulation Therapy | | |
| <input type="checkbox"/> Herniated Disc | | |
| <input type="checkbox"/> Sprain/Strain | | |
| <input type="checkbox"/> Fibromyalgia | | |
| <input type="checkbox"/> Carpal Tunnel Syndrome | | |
| <input type="checkbox"/> Lupus/Systemic Lupus Erythematosus (SLE) | | |
| <input type="checkbox"/> Muscular/Neuromuscular Disorder | | |
| <input type="checkbox"/> Degenerative Joint Disease | | |
| <input type="checkbox"/> Bunions | | |
| <input type="checkbox"/> Other _____ | | |
| Fixation/Prosthetic Device | | |
| <input type="checkbox"/> Plates | | |
| <input type="checkbox"/> Implants | | |
| <input type="checkbox"/> Pacemaker | | |
| <input type="checkbox"/> Screws | | |
| <input type="checkbox"/> Breast Implants | | |
| <input type="checkbox"/> Valve Replacement | | |
| <input type="checkbox"/> Pins | | |
| <input type="checkbox"/> Shunts | | |
| <input type="checkbox"/> Joint Replacement | | |
| <input type="checkbox"/> Transplants | | |
| Diabetes/Thyroid | | |
| <input type="checkbox"/> Diabetes | | |
| <input type="checkbox"/> High Blood Sugar | | |
| <input type="checkbox"/> Hyperglycemia | | |
| <input type="checkbox"/> Hypothyroid | | |
| <input type="checkbox"/> Pituitary Disorder | | |

Medical Conditions List *(continued)*

| Condition | Date Cond. Began | Person Being Treated/Treatment Provided |
|----------------------------------------------------------------|------------------|-----------------------------------------|
| <input type="checkbox"/> Low Blood Sugar | | |
| <input type="checkbox"/> Hyperthyroid | | |
| <input type="checkbox"/> Goiter | | |
| <input type="checkbox"/> Hypoglycemia | | |
| <input type="checkbox"/> Other _____ | | |
| Lungs and Respiratory System | | |
| <input type="checkbox"/> Hayfever/Allergies | | |
| <input type="checkbox"/> Sinus Infections | | |
| <input type="checkbox"/> Asthma | | |
| <input type="checkbox"/> Bronchitis | | |
| <input type="checkbox"/> Tuberculosis | | |
| <input type="checkbox"/> Pneumonia | | |
| <input type="checkbox"/> Chronic Cough or Shortness of Breath | | |
| <input type="checkbox"/> Emphysema | | |
| <input type="checkbox"/> Sleep Apnea | | |
| <input type="checkbox"/> Chronic Obstructive Pulmonary Disease | | |
| <input type="checkbox"/> Other _____ | | |
| Skin Disease | | |
| <input type="checkbox"/> Acne | | |
| <input type="checkbox"/> Skin Cancer | | |
| <input type="checkbox"/> Rosacea | | |
| <input type="checkbox"/> Eczema | | |
| <input type="checkbox"/> Psoriasis | | |
| <input type="checkbox"/> Other _____ | | |
| Tumor/Cyst/Growth | | |
| <input type="checkbox"/> Tumor | | |
| <input type="checkbox"/> Cyst | | |
| <input type="checkbox"/> Polyp | | |
| <input type="checkbox"/> Growth | | |
| <input type="checkbox"/> Other _____ | | |
| Ears/Eyes/Nose Disorders | | |
| <input type="checkbox"/> Ear Infections | | |
| <input type="checkbox"/> Ear Tubes | | |
| <input type="checkbox"/> Hearing Loss | | |
| <input type="checkbox"/> Speech/Hearing Impairment | | |
| <input type="checkbox"/> Meniere's Disease | | |
| <input type="checkbox"/> Tinnitus | | |
| <input type="checkbox"/> Labyrinthitis | | |
| <input type="checkbox"/> Tonsils/Adenoids | | |
| <input type="checkbox"/> Deviated Septum | | |
| <input type="checkbox"/> Cataracts | | |
| <input type="checkbox"/> Glaucoma | | |
| <input type="checkbox"/> Other _____ | | |
| Nervous System Disorders | | |
| <input type="checkbox"/> Unconsciousness or Fainting Spells | | |
| <input type="checkbox"/> Paralysis | | |
| <input type="checkbox"/> Cerebral Palsy | | |
| <input type="checkbox"/> Dementia or Alzheimer's | | |
| <input type="checkbox"/> Vertigo or Dizziness | | |
| <input type="checkbox"/> Multiple Sclerosis | | |
| <input type="checkbox"/> Bell's Palsy | | |

Medical Conditions List *(continued)*

| Condition | Date Cond. Began | Person Being Treated/Treatment Provided |
|------------------------------------------------------------------------|------------------|-----------------------------------------|
| <input type="checkbox"/> Parkinson's Disease | | |
| <input type="checkbox"/> Epilepsy/Seizures/Convulsions | | |
| <input type="checkbox"/> Headaches/Migraines | | |
| <input type="checkbox"/> Other _____ | | |
| Mental/Nervous Disorders | | |
| <input type="checkbox"/> Psychiatric Treatment or Counseling | | |
| <input type="checkbox"/> Anorexia | | |
| <input type="checkbox"/> Psychosis | | |
| <input type="checkbox"/> Anxiety | | |
| <input type="checkbox"/> Bulimia | | |
| <input type="checkbox"/> Panic Attacks | | |
| <input type="checkbox"/> Learning or Behavior Disorder | | |
| <input type="checkbox"/> Depression | | |
| <input type="checkbox"/> Attention Deficit Disorder | | |
| <input type="checkbox"/> Obsessive Compulsive Disorder | | |
| <input type="checkbox"/> Psychoneurotic Disorders | | |
| <input type="checkbox"/> Other _____ | | |
| Diagnostic Testing | | |
| <input type="checkbox"/> EKG (Electrocardiogram) | | |
| <input type="checkbox"/> Stress Test | | |
| <input type="checkbox"/> CT Scan | | |
| <input type="checkbox"/> Colonoscopy | | |
| <input type="checkbox"/> EEG | | |
| <input type="checkbox"/> Blood Test | | |
| <input type="checkbox"/> Chest X-Ray | | |
| <input type="checkbox"/> Angiogram | | |
| <input type="checkbox"/> Ultrasound | | |
| <input type="checkbox"/> EGD (Endoscopy) | | |
| <input type="checkbox"/> Bone Density | | |
| <input type="checkbox"/> Echocardiogram | | |
| <input type="checkbox"/> MRI | | |
| <input type="checkbox"/> Mammogram | | |
| <input type="checkbox"/> Holter Monitor | | |
| <input type="checkbox"/> Urinalysis | | |
| <input type="checkbox"/> Other _____ | | |
| Congenital Disorders/Birth Defects/ Developmental Disorders | | |
| <input type="checkbox"/> Down Syndrome | | |
| <input type="checkbox"/> Cleft Lip/Palate | | |
| <input type="checkbox"/> Speech Therapy | | |
| <input type="checkbox"/> Mental Retardation | | |
| <input type="checkbox"/> Club Foot | | |
| <input type="checkbox"/> Occupational Therapy | | |
| <input type="checkbox"/> Autism | | |
| <input type="checkbox"/> Congenital Heart Defects | | |
| <input type="checkbox"/> Physical Therapy | | |
| <input type="checkbox"/> Other _____ | | |