ATLANTALIFE®
General Agency

EFFECTIVE DATE:

_____

Email: ALGA@atlantalife.com
Phone: 404-654-8842
Fax: 404-654-8869

HEALTH INSURANCE-REFERRAL FORM

Agent Name: _____

Date: _____

Phone: _____

Business Email: _____

Customer Name: _____ Address: _____

Date of Birth: _____ _____

Height _____ft _____inches City: _____ State:_____ Zip:_____

Weight _____lbs Gender: Male ☐ Female ☐

Contact Phone Number: ( )____ - _____ Best Time to Call: _____

Email: _____

Do you have any dependents? If so, please list them below.

Name	Gender	Date of Birth	Relationship
1._____	_____	_____	_____
2._____	_____	_____	_____
3. _____	_____	_____	_____
4 ._____	_____	_____	_____

HEALTH QUESTIONS

Smoker ☐ Non-Smoker ☐

Do you have any past or current medical conditions?

Yes ☐ No ☐

If "yes", please explain in the space provided

Medical Issue(s) Explanation: (Insured/Dependent)

_____

_____

_____

_____

Are you on any medications?

Yes ☐ No ☐

If "yes", please list medication(s)

Current Medications: (Insured/ Dependent)

_____

_____

_____

Currently insured?

Yes ☐ No ☐