Individual Lead Page

Date:______________________________ Referred by:____________________

Client Name:________________________ Email:____________________

Address:___________________________ Zip Code:____________________

City:______________________________ County:______________________

Home#:______________ Business#:____________ Cell#:________________

Annualized Household Income: $________________ HIX: On or Off

Who is to be covered: Y or N

Primary Name:__________________ Gender:_______ DOB:__________ Smoker:

Spouse Name:__________________ Gender:_______ DOB:__________ Smoker:

Dependent: __________________ Gender:_______ DOB:__________ Smoker:

Dependent: __________________ Gender:_______ DOB:__________ Smoker:

Dependent: __________________ Gender:_______ DOB:__________ Smoker:

Policy Information:

Requested EOD:________________ Enrollment Option:___OEP___SEP
Type of Policy:________________ Type of SEP:__________________

Other Coverage Interested in (Circle Choices)

Accident Insurance Cancer Insurance Dental Insurance Disability Insurance

Final Expense Insurance Life Insurance Long-term Care Medicare 65+

Medicare Under 65 Vision Insurance

Doctors (unwilling to give up):

Name:______________ Specialty:____________ Location:____________________

Name:______________ Specialty:____________ Location:____________________

Name:______________ Specialty:____________ Location:____________________

Hospitals in Your Area:

Name:______________________________ Location:______________________________

Name:______________________________ Location:______________________________

Prescription Drugs:

Name:______________________________ Dosage:________ Times a day:______

Name:______________________________ Dosage:________ Times a day:______

Name:______________________________ Dosage:________ Times a day:______

For Office Use Only Below:

Carriers Quoted:

Medical Mutual:___ Ambetter:

Molina Healthcare:___ CareSource:___ Oscar:___

Plan Sold:

Plan EOD:_____________ Carrier:_______________ Plan Name:_____________________

HIX: On or Off Plans Full Premium: $_____________ Tax Credits: $_____________

Client Pays Monthly: $_______________ Payment @ Time of Sale to Carrier: Y or N

Plan EOD:_____________ Carrier:_______________ Plan Name:_____________________

Plans Full Premium:$___________ Payment @ Time of Sale to Carrier: Y or N

Items to be handled in House After Sold

Submit Sold Case to Carrier:

- Direct to Carrier Y or N Date:____________ Initials:_________
- Completed on HIX Y or N Date:____________ Initials:_________

Confirmation of Sold Case Received:

- Direct to Carrier Y or N Date:____________ Initials:_________
- From HIX Y or N Date:____________ Initials:_________
- HIX Application #:

Client File:

- Create New Client File: Y or N Date:____________ Initials:
- Create Sales Sheet: Y or N Date:____________ Initials:_________
- Add to Excel Sheet: Y or N Date:____________ Initials:_________
- Send Thank You Letter: Y or N Date:____________ Initials:_________
- Referral Thank You Letter: Y or N Date:____________ Initials:_________

Sales Agent:____

Please Note: All forms may be filled out electronically.
Download the desired form to your local device and save.
Complete the form and click the EMAIL button to submit electronically.
For hard copy submissions, click the PRINT button and mail or fax to us at:
Insurance Strategy Inc., 6368 Pearl Road, Cleveland, Ohio 44130; Fax: 440-842-8669
Acrobat Reader is required. Click the logo to download the software.