

SMITTY INSURANCE

Financially Protecting You NOW & Through Retirement

INSURED ONLY Intake Form

Primary Insured Legal Full Name: _____ Initials _____

Phone#: _____ Email: _____

Address _____ City _____ ST _____ ZIP _____

Birth Date: _____ State Born in (XX) _____ SSN: _____

Height ____' ____" Weight _____ Tobacco Use: Y/N SEX: M/F US Citizen Y/N

Driver License _____ ST _____ (XX)

Your Gross Annual Income: _____ Est. Household Income _____ Employed Y/N

Employer _____ JOB TITLE: _____ Hire Date (M/YR) _____

HEALTH PROVIDER INFORMATION

PREFERRED PRIMARY DOCTOR (PCP) _____

Practice _____ PH _____

Address _____ City _____ ST _____

Last Visit (M/Yr) _____ Reason _____

PREFERRED HEALTH SPECIALIST _____

Practice _____ PH _____

Address _____ City _____ ST _____

Last Visit (M/Yr) _____ Reason _____

PREFERRED HOSPITAL _____ PH _____

Address _____ City _____ ST _____

Last Visit (M/Yr) _____ Reason _____

PREFERRED DENTIST _____

Practice _____ PH _____

Address _____ City _____ ST _____

Last Visit (M/Yr) _____ Reason _____

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PREFERRED EYE DOCTOR _____

Practice _____ **PH** _____

Address _____ **City** _____ **ST** _____

Last Visit (M/Yr) _____ **Reason** _____

PHARMACY NAME _____

Address _____ **City** _____ **ST** _____ **ZIP** _____

PH _____ or **Online Pharmacy** _____

You: Within Last 5 years Chronic or Major Medical Treatment (Planned as well)

1. Medical Procedures _____

a. Initial Diagnosis _____ M/YR; Medicare Treatment _____ M/YR

2. Medical Procedures _____

a. Initial Diagnosis _____ M/YR; Medicare Treatment _____ M/YR

Family History of Chronic or Major Medical Events

Family Member Relation _____ **DOB** _____

Medical Condition _____

Prescription Drugs (Currently Taking)

1. _____ Dosage: _____ Quantity/#times/Day _____ Refills: 30/60/90days

2. _____ Dosage: _____ Quantity/#times/Day _____ Refills: 30/60/90days

3. _____ Dosage: _____ Quantity/#times/Day _____ Refills: 30/60/90days

4. _____ Dosage: _____ Quantity/#times/Day _____ Refills: 30/60/90days

5. _____ Dosage: _____ Quantity/#times/Day _____ Refills: 30/60/90days

6. _____ Dosage: _____ Quantity/#times/Day _____ Refills: 30/60/90days

7. _____ Dosage: _____ Quantity/#times/Day _____ Refills: 30/60/90days

8. _____ Dosage: _____ Quantity/#times/Day _____ Refills: 30/60/90days

9. _____ Dosage: _____ Quantity/#times/Day _____ Refills: 30/60/90days

10. _____ Dosage: _____ Quantity/#times/Day _____ Refills: 30/60/90days

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Eligibility Questions

1. Are you married? Y/N

a. If YES,

First Name_____ Last Name_____

DOB_____ SEX M/F Does this person live with you? Y/N

2. Do you plan to file a federal income tax return for 2026? Y/N

3. Are you claiming any dependents on your taxes for 2026? Y/N

a. IF YES,

First Name_____ Last Name_____

DOB_____ SEX M/F Does this person live with you? Y/N Relationship to
you_____

4. Do you live with any other non-dependent people under age 19 who are not being considered for
benefits? Y/N

a. If Yes Are you the primary person taking care of the child under 19? Y/N

First Name_____ Last Name_____

DOB_____ SEX M/F Does this person live with you? Y/N Relationship to
you_____

5. Do you have any Tax Deductions ? Y/N

a. If Yes, Alimony___ Student Loans___ Other_____