

BURAK INSURANCE

SOLUTIONS

AN INDEPENDENT INSURANCE AGENT

One Call For All Your Personal and Business Insurance Needs

Dear Potential Applicant:

Thank you for your interest in Burak Insurance Solutions and our expertise in obtaining the most competitive insurance quotes in the industry for the Georgia market. We know how important it is to have the best value for your insurance products.

Please complete the form provided on the following page at your convenience. After completion, please print and fax this form to 770-521-1420. We will review this form for completeness and contact you for any additional information needed to acquire the best quotes.

Again, we thank you for interest and look forward to serving you in the future.

Sincerely,

Frederick L. Burak

Frederick L. Burak

Insurance Profile for Medicare and Long Term Care Insurance Products

<input type="checkbox"/> Group <input type="checkbox"/> Individual	<input type="checkbox"/> Life Amount: \$	<input type="checkbox"/> 10 Yr.	<input type="checkbox"/> 15 Yr.	<input type="checkbox"/> 20 Yr.	<input type="checkbox"/> 25 Yr.	<input type="checkbox"/> 30 Yr.	<input type="checkbox"/> UL
<input type="checkbox"/> Family	<input type="checkbox"/> Disability Monthly Amount @ 50% Average last 2 years income: \$						

For Group - Employer name, address, phone number, Contact Person name:

Primary Applicant Name			Sex	DOB	Age	Height	Weight	Smoker?
Home Street Address			City			State	Zip Code	
Home Phone	Work Phone	Occupation			Payroll Information <input type="checkbox"/> Mgmt <input type="checkbox"/> Salaried <input type="checkbox"/> Hourly			

Medications & Related Condition

Medication Name	Date Stated	Dosage	Frequency	Condition
1.				
2.				
3.				
4.				
5.				

Medical Treatment Last 12 Months (attach separate piece of paper if more room needed)

Condition	Date Diagnosed	Treatment & Results

Spouse Name			Occupation	Sex	DOB	Age	Height	Weight	Smoker?
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Medications & Related Condition (attach piece of paper if more room needed)

Medication Name	Date Started	Dosage	Frequency	Condition
1.				
2.				
3.				
4.				

Medical Treatment Last 12 Months (attach piece of paper if more room needed)

Condition	Date Diagnosed	Treatment & Results

Child(ren) Name	Sex	Birth Date	Age	Height	Weight

Medical Treatment For Children Last 12 Months (attach additional page if more room needed)

Child Name	Treatment

Current Health Insurance Carrier Name	Current Plan Deductible \$	Current Plan Coinsurance \$	Monthly Premium \$
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