AMS BENEFITS, INC.

A wholly-owned subsidiary of the Arkansas Medical Society

Individual Health Insurance Proposal Request

Office: 501-224-8967 Toll Free: 1-800-542-1058 Fax: 501-224-6489

Please either fax your request or e-mail it to amsbenf@arkmed.org

Name: _____ ***Contact Number:*** _____

Date of Birth: _____ ***Gender:*** _____ ***State of Residence:***_____

Zip Code: _____ ***County:*** _____

Spouse Name: _____ ***Date of Birth:*** _____

Tobacco User: ***Yes:*** _____ ***(Type:*** _____ ***)*** ***No:***_____

Dependents

Gender: _____ ***Date of Birth:*** _____
Gender: _____ ***Date of Birth:*** _____

Please Quote Deductible:

$500 ____ $1000 ____
$2500 ____ $5000 ____

Type of Plan Desired:

PPO _____
HSA _____

Primary Care Co-Pay ___yes ____no **Specialty Co-Pay** ___yes ____no

Dental Insurance ____yes ____no **Vision Insurance** ____yes _____no

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If you are applying for coverage outside of the annual open enrollment period, please indicate if you have had a loss in other coverage or a qualifying life event. _____ ***yes*** _____ ***no***