FORTIS INSURANCE COMPANY
SMALL GROUP PRE-SCREEN REQUEST

This form may be E-mailed, faxed or Groupwised for a proposed rating to your Sales Representative.

Proposed rates/surcharges are not binding and final approval will only be given following receipt and approval of properly completed applications. Any changes in group composition or medical history may require additional evaluation. Fortis Insurance Company complies with all State and Federal mandated requirements regarding the acceptance and issuance of Small Group Medical coverage.

Group Name: ______________________________ State: __________

Nature of Business: ______________________________

Agent Name: ______________________________ Agent Phone: ______________

Agent Fax: ______________ Agent E-Mail Address: ______________________

Number of Medical Certs: Single ____________ Employee/Spouse ________

Employee/Child ________ Full Family ____________

Total Number of Children to be Covered ____________

The estimated rating is valid for 60 days after the date indicated.

Home Office Use Only:	Estimated Rating	Reviewed By	Date

For all conditions, please list exact diagnosis, dates of treatment, method of treatment, including all medications, and prognosis for future treatment/resolution.

Applicant Name: ______________________________ Age: __________

☐ Male ☐ Female Tobacco Use: ☐ Yes ☐ No Ht/Wt: __________

Medical History: ☐ Details on Supplement

Applicant Name: ______________________________ Age: __________

☐ Male ☐ Female Tobacco Use: ☐ Yes ☐ No Ht/Wt: __________

Medical History: ☐ Details on Supplement

Applicant Name: ______________________________ Age: __________

☐ Male ☐ Female Tobacco Use: ☐ Yes ☐ No Ht/Wt: __________

Medical History: ☐ Details on Supplement

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Medical History: ☐ Details on Supplement