



Individual Health
From Word & Brown

(800) 869-6989
(714) 835-6752
X4657

FAX (714) 953-9404

CALIFORNIA PRODUCT PORTFOLIO

EFFECTIVE
APRIL 1, 2002

INDIVIDUAL PLANS

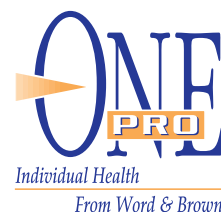
CARRIER	HMO/EPO PLAN NAME	FIRST YEAR COMMISSION
Blue Shield	Access + HMO	Tier I 15%
		Tier II 12%
		Tier III 9.60%
		Tier IIII 8%
		Tier V 4.80%
Health Net	Elect Open Access HMO 15 HMO 40	All plans: 10%
Universal Care	Plan 10 Plan 20	All plans: 15%
ChampionHealth Network	Plan 10 Plan 20	

CARRIER	DENTAL PLAN NAME	FIRST YEAR COMMISSION
California Dental Network (CDN)	Plan 411	10%
Denticare/AVP	Vis-A-Dent D-150 Vis-A-Dent D-250	20%
		10%
Fidelity Security Life	The One Dental Plan	10%
Golden West	Smilechoice Plan 2	20%
Nationwide	Delta Adaptable DeltaCare	9%
		9%
SmileSaver	GE 600 GE 400	20%
		10%

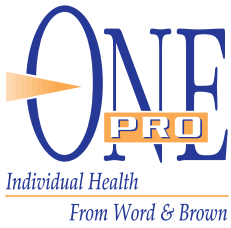
CARRIER	PPO PLAN NAME	FIRST YEAR COMMISSION
Blue Shield	High Deductible Preferred Savings†	All Plans: 15%
Fidelity Security Life	The 100% Plan Complete Care 90/60 Complete Care 80/60	All Plans: 15%
Health Net	Executive PPO 20 Optimum PPO 10 Value PPO	All Plans: 10%
Nationwide	Choice	Tier I 23%
		Tier II 19%
		Tier III 16%
	Select 25 & 40	Tier II 18%
		Tier II 15%
		Tier III 13%
Primary \$30 & \$45	Tier II 18%	
	Tier II 13%	
	Tier III 9%	

CARRIER	MEDICARE SUPPLEMENT PLAN NAME	FIRST YEAR COMMISSION
Nationwide	Medicare Supplement	9%

†Medical Savings Account (MSA) compatible



**PLEASE SEE OTHER SIDE FOR INDIVIDUAL
PROPOSAL REQUEST FORM**



721 SO. PARKER, SUITE 300
ORANGE, CA 92868

FAX: (714) 953-9404

(800) 869-6989
X4657

PHONE IN
YOUR QUOTE!
CALL OUR QUOTING AT
(800) 869-6989 EXT. 4904

Individual Health Proposal Request

BROKER INFORMATION

BROKER LICENSE #

BROKER CODE (IF KNOWN)

CHECK IF
NEW ADDRESS

BROKER NAME _____

AGENCY _____

ADDRESS _____

CITY _____, CA ZIP _____

PHONE (____) _____ FAX (____) _____

E-MAIL ADDRESS _____

DELIVERY OF PROPOSAL:

(CHECK ALL THAT APPLY)

WILL PICK UP AT:
(CHECK LOCATION)

MAIL COMPLETE
PROPOSAL

FAX/MAIL
SUMMARY PAGES

ORANGE

721 SO. PARKER
SUITE 300
ORANGE, CA 92868

SAN DIEGO

3131 CAMINO del RIO NO.
SUITE 260
SAN DIEGO, CA 92108

ENCINO

16830 VENTURA BLVD.
SUITE 360
ENCINO, CA 91436

SAN JOSE

1737 N. FIRST STREET
SUITE 280
SAN JOSE, CA 95112

INDIVIDUAL INFORMATION

ALL ITEMS MUST BE COMPLETED IN FULL

NAME OF INSURED _____

CITY _____, CA ZIP _____

1) CURRENT OCCUPATIONAL STATUS:

- EMPLOYED SELF-EMPLOYED
 STUDENT UNEMPLOYED
 CHILD

2) JOB TITLE: _____

EMPLOYER'S SPECIFIC INDUSTRY _____

CHECK IF OFFICE EMPLOYEE ONLY

SPOUSE'S JOB TITLE: _____

EMPLOYER'S SPECIFIC INDUSTRY _____

CHECK IF OFFICE EMPLOYEE ONLY

BENEFIT INFORMATION

Maternity, Rx Card and Supplemental Accident will always be quoted if available as options

1) DESIRED EFFECTIVE DATE ____/____/____

2) DEDUCTIBLE: \$0-250 \$250-500
 \$500-\$1000 \$1000 +

HEALTH INFORMATION

1) CURRENTLY PREGNANT? YES NO
(IF YES, DELIVERY DATE: ____/____/____)
(IF YES, CALL REP PRIOR TO QUOTING)

2) SIGNIFICANT MEDICAL HISTORY:

CENSUS INFORMATION

RELATIONSHIP	SEX	AGE/DATE OF BIRTH	FULL-TIME STUDENT*
INSURED →	FOR BEST RATE, LIST YOUNGER SPOUSE AS "INSURED"...		N/A
SPOUSE	...THEN LIST OLDER "SPOUSE" HERE		N/A
CHILD #1			
CHILD #2			
CHILD #3			
CHILD #4			
CHILD #5			
CHILD #6			
CHILD #7			

*IF CHILD IS OVER THE AGE OF 18, PLEASE MARK YES IF FULL TIME STUDENT.
FOR ADDITIONAL CHILDREN, PLEASE USE SEPARATE SHEET.