

# WARNER PACIFIC

INSURANCE SERVICES

## Individual Underwriting Prescreen Form - Colorado

Fax to Jane Rasmussen at (303) 771-6500 or

Email to [coindividualprescreen@warnerpacific.com](mailto:coindividualprescreen@warnerpacific.com)

For questions, please call (800) 801-2300 x6109

### **Underwriting Prescreening Form (24-48 hour turnaround time)**

This form should be used for underwriting questions related to Individuals and Families prior to submitting an application. For questions related to an application that has already been submitted, please contact your assigned underwriter, Maria Syed x444 or Rita Peterson x113.

Please do not include the following:

- Names
- Social security numbers.
- Attachments or applications.
- Medical records

*Please complete all requested info below and on the other side of this form:*

Today's Date*: (MM/DD/YYYY)	
Requested Effective Date: (MM/DD/YYYY)	
Broker Name/Agency*:	
Broker E-Mail Address*:	
State*:	
<i>Applicant's</i> Zip Code*:	

*\*Required fields*

### Check the carriers that you would like to pre-screen:

Anthem <sup>1</sup>  Assurant  CIGNA  HumanaOne  Kaiser

**In order to initiate a prescreen, you must be appointed with the carrier and Warner Pacific as the GA. For appointment information please contact us at [agentappointments@warnerpacific.com](mailto:agentappointments@warnerpacific.com). No prescreen can be released prior to affiliation with Warner.**

<sup>1</sup>Anthem: Please let us know if you are interested in a Tonik plan as they are underwritten differently from all other Anthem plans.

Family Member	Initials*	Gender (M/F)*	Age*	Height (Feet)*	Height (Inches)*	Weight (lbs)*	Smoker (Y/N)*
Primary Applicant*							
Spouse							
Dependent #1							
Dependent #2							
Dependent #3							
Dependent #4							
Dependent #5							

**\*Required fields**

If we are prescreening HumanaOne or Anthem, please let us know if the client will be taking (circle or highlight the answer):

- a. Deductible under 2500
- b. Deductible over 2500
- c. Deductible over 5000
- d. HSA or a high deductible plan

<b>*Please complete the following medical information:</b>				
Family Member (initials)	Diagnosis/Condition (reason behind diagnosis and the date of the onset of the condition)		Medication	Details (please include current readings on the condition)
	Condition	Date Condition Started		

**\*Required fields**

<b>ADDITIONAL COMMENTS:</b>