



MAR Blue Cross Program Information Sheet "Request for Proposal" (for One Subscriber Group)

Please print and complete the following information and fax to
Group Associates at 248 593-2065 for a personalized medical insurance proposal.
If you have any questions while completing this form, you may call 800 342-8908 x 2810.
Thank you for your interest.

Your personal information

Michigan

First Name
Middle Initial
Last Name
Birth date
If you are over age 65, are you enrolled for Medicare? (Part A & B)
Gender
Home street address
Home city
Home zip code
Home State
Home phone number (optional)

Your family members' information

Spouse name (or "none")
Spouse birth date
If you have a spouse over age 65, is your spouse enrolled for Medicare? (Part A & B)
Number of dependent children born after 12/31/1987
Number of dependent children born after 01/01/1982, but before 12/31/1987

Your professional information

Year started as a REALTOR
Work street address
Work city
Michigan
Work State
Work zip code
Work phone number
Work facsimile number (optional)
Mobile phone number (optional)
email address (optional)

Information Blue Cross underwriters ask to determine your eligibility to participate in the MAR Blue Cross program

Are you the primary income earner in your household, if married?
Does your spouse qualify for medical insurance from her/his employment?
Date completed