

HEALTH INSURANCE QUESTIONNAIRE

General Information

Group Name _____ Date: _____

Mailing Address _____

City _____ County _____ State _____ Zip _____

Phone Number _____ Fax Number _____

Email Address _____

Employee Information

	Name	Sex	DOB	Spouse DOB	Number/ Children	Type of Coverage (Single, Emp/Child, Emp/Sp or Emp/Children, Family)
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	Name	Sex	DOB	Spouse DOB	Number/ Children	Type of Coverage (Single, Emp/Child, Emp/Sp, Family)
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SCMA Financial Services, Inc.
A subsidiary of the South Carolina Medical Association

1.800.327.1021
803.750.1115 fax
P.O. Box 21667
Columbia, SC 29221
www.scmafs.com