PLEASE DO NOT SEND MORE THAN ONE COPY
(EMAIL, FAX OR SNAIL MAIL)
SEPARATE SHEETS PER PERSON

****PLEASE FILL OUT ALL FIELDS TO AVOID DELAY ****

AGENT:

* Please do not list vitamins or over-the-counter medications
* If you take pills only "as needed" please put the average quantity you use per month
* If you use insulin, indicate how many pens or vials per month
* If you use a cream or gel, indicate how many tubes or bottles (and WHAT SIZE) per MONTH
* If you use inhalers, indicate how long one lasts

Name:_____ **Phone:**_____ **Date:**_____

Address:_____ **City:**_____ **County:**_____ **Zip:**_____

Email:_____ **CURRENT DRUG PLAN:** _____

Pharmacy: _____ **Pharmacy #2:** (Only if you're willing to change) _____ **Mail Order: Yes**☐ **No**☐

Medication Name (DO NOT LIST ANY OVER THE COUNTER DRUGS)	Capsule or Tablet	Dosage	Daily Quantity	Tubes/Bottles Pens/Vials (Per Mo)	Is Generic OK? Yes or No

Valery Insurance Agency, 2113 Gulf Blvd, Indian Rocks Beach, FL 33785, Fax: (727) 517-8887, E-mail: info@valeryagency.com