Health Insurance Questionnaire

Reents insurance agency

Contact Name: _____ Email: _____

City: _____ County: _____ Zip Code: _____ Phone: _____

Referred By: _____ Date: _____

Occupation: _____ Self Employed?: No _____

Part I: Financial Assistance Information (if you want us to check eligibility)

How many people will be claimed on your Federal tax return for 2019? _____

Based on your best guess, what will your total household income be in 2019? _____

This would be your modified adjusted gross income (line 37 of the 1040) plus any foreign and tax exempt income.

Are you, or anyone to be insured, currently pregnant? _____

Are you or anyone to be insured *eligible* for group insurance? _____

Part II: Current Coverage

Current Plan Name (carrier, hmo/ppo/pos, etc.): _____

Current Premium: _____

Current providers you want in-network on new plan: (rank in order of importance)

_____

_____

_____

Part III: About You

*For purposes of determining your eligibility for financial assistance, please provide the following information **for everyone in the tax household**.*

First Name	*Date-of-birth*	*Relationship*	*Tobacco use?*	***To be Insured?***
		Self	No	Yes
			No	Yes
			No	Yes
			No	Yes
			No	Yes
			No	Yes

Additional Information: _____

_____

_____

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