Health Insurance Questionnaire

Contact Name: ______________________ Email: ______________________

City: __________ County: __________ Zip Code: __________ Phone: __________

Referred By: ______________________ Date: __________

Occupation: ______________________ Self Employed?: __________

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

How many people will be claimed on your Federal tax return for 2020? __________

Based on your best guess, what will your total household income be in 2020? __________

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)

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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		

Additional Information: ______________________

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