

# 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 2021?** \_\_\_\_\_

**Based on your best guess, what will your total household income be in 2021?** \_\_\_\_\_

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	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Additional Information: \_\_\_\_\_