

Health Insurance Questionnaire



Contact Name: _____ Email: _____
 City: _____ County: _____ Zip Code: _____ Phone: _____
 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 2026 _____

Based on your best guess, what will your total household income be in 2026 _____

(Adjusted gross income plus untaxed foreign income, non-taxable Social Security benefits, and tax-exempt interest.)

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

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

Part II: Current Coverage

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

Current Premium: _____

Providers you want in-network on new plan (rank in order of importance) and List of medications

Part III: About You

For purposes of determining your eligibility for financial assistance, please provide the following information for everyone in the tax household even if not applying for insurance.

First Name	Date-of-birth	Relationship	Tobacco use?	To be Insured?
_____	_____	Self	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Additional Information: _____

