Health Insurance Questionnaire

Reents insurance agency

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 2027 _____

Based on your best guess, what will your total household income be in 2027 _____

(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: _____

_____

_____

_____

Telephone (303) 756-2663

james@reentsinsuranceagency.com