

# Health Insurance Questionnaire



Contact Name: \_\_\_\_\_ Email: \_\_\_\_\_  
City: \_\_\_\_\_ County: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_  
Referred By: \_\_\_\_\_ Date: \_\_\_\_\_

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

**How many people will be on your Federal tax return for 2017?**

**Based on your best guess, what will your total household income be in 2017?**

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 (from ID card): \_\_\_\_\_

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 household.*

<i>First Name</i>	<i>Date-of-birth</i>	<i>Relationship</i>	<i>Tobacco use?</i>	<i>To be Insured?</i>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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