Individual/Family Questionnaire

1) Applicant(s) Name –
   a)
   b)
   c)
   d)
   e)
   f)

2) Date of Birth of applicant(s)-
   a)
   b)
   c)
   d)
   e)
   f)

Contact Information: (*Please Complete*)

1) Primary Contact:

2) Phone #:

mobile -

home -

work -

3) Email for Quoting Purposes:

Referred by:

3) Address w/ Zip Code where coverage will take place in. -

4) Tobacco User- (smoking, chewing tobacco, etc.)
   List applicants that are tobacco users

5) Current Health Coverage –

   Health Carrier ________________ Cost ________________

6) Requested effective date -

7) Please list current doctors being seen, even specialists (for all applicants) *Please include facility doctor is associated with and the doctors specialty (PCP,Pediatrics,etc.)*

8) Full Names of Medications presently being taken, what medication is used for, and dosage for all applicants (for all applicants) *Please include beginning date of use.*

a)

b)

c)

d)

e)

f)

9) To see if you/family are eligible for a subsidy (help from the government to pay your health insurance premium) please include the following:

HOUSEHOLD SIZE _______

Estimated Annual (Gross) Income: 2015 ____________________

2016 ____________________

(If additional space is required please attached separate sheet of paper)