Individual/Family Questionnaire

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

Date:

Contact Information: (*Please Complete*)

1) Primary Contact:

2) Phone #:

mobile -
home -
work -

3) Email for Quoting Purposes:

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

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)

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: 2017 _____

2018 _____

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