Ace Value Enterprise Health Insurance Application Referred By:

This document contains confidential information that is intended for use Only by the individual to whom it is addressed. By signing below, the applicant gives permission for the agent to assist in acquiring health insurance or any additional insurance requested.

Demographics Section:

COUNTY_____ AGENT'S NAME: Comeile Johnson DATE

Current Insurance: _____ SEX Needs Coverage?

APPLICANT_____DOB_____ SS#_____ M/F Y/N
SPOUSE _____ DOB _____ SS# _____ M/F Y/N
CHILD_____DOB_____SS#_____M/F Y/N
CHILD_____DOB_____SS#_____ M/F Y/N
CHILD _____ DOB _____SS# _____ M/F Y/N

Income Section:

HOME ADDRESS_____ APT #_____

CITY _____STATE_____ZIP CODE_____

PHONE NUMBER _____ EMAIL ADDRESS_____

MARITAL STATUS_____ *IF MARRIED MUST FILE JOINTLY WITH SPOUSE FOR SUBSIDY*

EST INCOME FOR NEXT YEAR, APPLICANT: $_____ SPOUSE: $_____

SELF EMP? Y/N APPLICANT EMPLOYER_____EMP PHONE #_____

SPOUSE EMPLOYER AND PHONE NUMBER_____

Eligibility:

US CITIZEN: Y/N IF NOT US CITIZEN, WHAT PROOF AVAILABLE? GREEN CARD, VISA

GREEN CARD NUMBER_____ALIEN NUMBER_____

SPOUSE GC NUMBER_____ALIEN NUMBER

FILED TAXES LAST YEAR? Y/N

Plan Information:

PLAN NAME_____ MONTHLY SUBSIDY_____

PREMIUM_____ Payment Information:

VISA/MC_____EXP_____SEC CODE_____ Debit Card?

CHECKING INFO:

ROUTING_____ACCT_____

All Payment due upon submission.

PRIMARY CARE PHYSICIAN?

APPLICANT_____SPOUSE_____

CHILD

DATA ENTRY CLERK:_____APPLICANT'S SIGN:_____

If filling out the application on paper. Be sure to Scan/email, Fax or text to:

acevalueenterprise@gmail.com, Fax # 954-368-3002, Text: 786-298-4992