HEALTH INSURANCE QUESTIONAIRE - INDIVIDUAL/FAMILY COVERAGE

email to: Lynne@InsAdvocates.com

PERSONAL INFORMATION – **APPLYING**? Y/N_____

Full Legal Name_____

SSN_____DOB_____

Email_____

Cell_____Other_____

Street Address_____

City_____County_____

State_____ Zip_____

US Citizen? Y/N____ Gender: M/F_____ Single___Married___

Tobacco Use?Y/N___ If yes, date last used_____

Does your Employer offer coverage at work?_____

Are there others at your job who may need coverage?_____

Tax Return Filed: Joint____ Single____

What Year Taxes did you file already_____

What is your MAGI on Tax Return $_____

How many dependent(s) on Tax Return including yourself_____

Did you recently Move/Have Baby/Get Married/Divorced

_____

DEPENDENT INFORMATION (*If Applicable*)

Child Full Name_____

SSN_____DOB_____

Y/N: US Citizen? ___ Lives at Home? ___ **APPLYING**? ____

Child Full Name_____

SSN_____DOB_____

Y/N: US Citizen? ___ Lives at Home? ___ **APPLYING**? ____

Child Full Name_____

SSN_____DOB_____

Y/N: US Citizen? ___ Lives at Home? ___ **APPLYING**? ____

Child Full Name_____

SSN_____DOB_____

Y/N: US Citizen? ___ Lives at Home? ___ **APPLYING**? ____

Who Referred you to us :_____

SPOUSE'S INFORMATION – **APPLYING**? Y/N_____

Full Legal Name_____

SSN_____DOB_____

Email_____

Cell_____Other_____

State_____ Zip_____

US Citizen? Y/N____ Gender: M/F_____

Tobacco Use?Y/N___ If yes, date last used_____

Are you offered Health Insurance where you work?_____

Yes/is the cost of dependent coverage affordable to you?_____

Did you recently Lose Coverage Y/N ____Date_____
From Employer Y/N____
Do you currently have health insurance? Y/N_____
Insurance Carrier_____
Current Monthly Premium $_____
Pref Type of Plan: __PPO __HMO/EPO __Low Cost
What is your monthly Budget $_____

Are you/spouse/dependents on Medicaid or Medicare?_Y/N_____

LIST OF DOCTORS

PRIMARY CARE DOCTORS	TYPE OF DOC	PHONE	YOU/SPOUSE OR CHILD

SPECIALIST DOCTOR (GYN/PEDS)	TYPE OF DOC	PHONE	YOU/SPOUSE OR CHILD

PRESCRIPTIONS

NAME OF DRUG	GENERIC OK	DOSAGE/PILL/TABLET/INJECTABLE/ETC	PER DAY

MEDICAL CONDITIONS or SERIOUS ISSUES/TREATMENTS FOR US TO BE AWARE OF /Other Comments	YOU/SPOUSE OR CHILD

Attach the signed Consent form

Enrollment consent form

I, _____ [name of primary household contact], give my permission to Lynne Clausn [name of the person or entity who has the consumer's consent] ("Agent") to serve as the health insurance Agent or broker for myself and my entire household if applicable, for purposes of enrollment in a Qualified Health Plan offered on the Federally Facilitated Marketplace. By consenting to this agreement, I authorize the above-mentioned Agent to view and use the confidential information provided by me in writing, electronically, or by phone only for one or more of the following:

- Searching for an existing Marketplace application
- Completing an application for eligibility and enrollment in a Marketplace Qualified Health Plan or other government insurance affordability programs, such as Medicaid and CHIP or advance tax credits to help pay for Marketplace premiums
- Providing ongoing account maintenance and enrollment assistance, as necessary
- Responding to inquiries from the Marketplace regarding my application

I understand that the Agent will not use or share my personally identifiable information (PII) for any purposes other than those listed above. The Agent will ensure that my PII is kept private and safe when collecting, storing, and using my PII for the stated purposes above.

- I confirm that the information I provide for entry on my Marketplace eligibility and enrollment application will be true to the best of my knowledge.
- I confirm that I have reviewed my completed application and that all information is accurate.

I understand that I do not have to share additional personal information about myself or my health with my Agent beyond what is required on the application for eligibility and enrollment purposes. I understand that my consent remains in effect until I revoke it, and I may revoke or modify my consent at any time by contacting my Agent.

Primary Writing Agent

Name of primary writing Agent: **Lynne Clausen**

Agent National Producer Number: **5721599**

Phone number: **863-588-1582**

Email address: **Lynne@InsAdvocates.com**

Agency (if applicable)

Name of Agency: **Your Health Insurance Advocates, LLC**

National Producer Number: **5721599**

Owner of Agency: **Lynne Clausen**

Phone number: **863-588-1615**

Email address: **Lynne@InsAdvocates.com**

Name of primary household contact: _____

Power of Attorney/Representative (if applicable): _____

Phone number: _____

Email address: _____

Primary applicant SIGN HERE Date_____