Section 1: Contact Information

Name: _____ Date: _____

Address: _____

City: _____ State: _____ County: _____ Zip: _____

Email: _____ Best Phone No: _____

Referral: _____

Provide DOB for only those family members needing coverage.

Insured date of birth: ____/____/____ Tobacco: yes☐☐no Name _____

Spouse date of birth: ____/____/____ Tobacco: yes☐☐no Name _____

Children date of birth: ____/____/____ Tobacco: yes☐☐no Name _____

Children date of birth: ____/____/____ Tobacco: yes☐☐no Name _____

Children date of birth: ____/____/____ Tobacco: yes☐☐no Name _____

Children date of birth: ____/____/____ Tobacco: yes☐☐no Name _____

Children date of birth: ____/____/____ Tobacco: yes☐☐no Name _____

Premium tax credits are calculated by household income and number of family members claimed on tax return.

MARRIED? Please circle: Yes ☐ or No ☐

- Estimated family household income for the year the coverage is needed. _____
- Number of family members claimed on tax return for the year the coverage is needed._____
- Are you and or your spouse offered employer group health coverage? Yes ☐ No ☐

Section 2: Marketplace Agent Information Needed

***When completing online application on your own please use this information when the question is asked:**

"Application Help?" Is a professional helping you complete? **YES**

Choose: Agent/Broker and enter these two pieces of information

Name: _____ National Producer Number **(NPN):** _____

Section 3: Are you Interested in Additional Benefits?

Life ☐ Dental ☐ Vision ☐

Accidental, Hospital Gap Plans, Critical Illness & Cancer ☐