EMPLOYEE CONTACT INFORMATION

Name: _____ Date: _____
Address: _____
City: _____State: _____County: _____Zip: _____
Email: _____ Best Phone No: (____)_____-_____

Provide DOB for only those family members needing coverage.

Insured date of birth: _____/_____/_____ Tobacco: yes or no Name_____
Spouse date of birth: _____/_____/_____ Tobacco: yes or no Name_____
Children date of birth: _____/_____/_____ Tobacco: yes or no Name_____
Children date of birth: _____/_____/_____ Tobacco: yes or no Name_____
Children date of birth: _____/_____/_____ Tobacco: yes or no Name_____
Children date of birth: _____/_____/_____ Tobacco: yes or no Name_____
Children date of birth: _____/_____/_____ Tobacco: yes or no Name_____

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

- 2023 Estimated family household income _____
- Total number of family members claimed on 2023 tax return (include yourself) _____
- Are you and or your spouse offered employer group health coverage? Yes or No
- Married? Yes or No
- Do you or any family members currently have Medicaid/Medicare? Yes or NO
- If changing jobs, when did you loose coverage? _____