EMPLOYEE CONTACT INFORMATION

Name: _____ Date: _____
Address: _____
City: _____State:_____County:_____Zip: _____
Email: _____ Best Phone Num: _____

Provide DOB for only those family members needing coverage.

Insured date of birth: _____ Tobacco: Y◯ N◯ Name: _____ Gender:
Spouse date of birth: _____ Tobacco: Y◯ N◯ Name: _____ Gender:
Children date of birth: _____ Tobacco: Y◯ N◯ Name: _____ Gender:
Children date of birth: _____ Tobacco: Y◯ N◯ Name: _____ Gender:
Children date of birth: _____ Tobacco: Y◯ N◯ Name: _____ Gender:
Children date of birth: _____ Tobacco: Y◯ N◯ Name: _____ Gender:
Children date of birth: _____ Tobacco: Y◯ N◯ Name: _____ Gender:

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

Please answer all the questions

- Estimated family taxable income for the year coverage is needed.
- Employee Income: $_____ Spouse Income: $_____ Dependents Income: $_____
- Total number of family members claimed on tax return for the year coverage is active (include yourself) ____
- Are you and/or your spouse offered employer group health coverage? Y◯ N◯
  If yes, please specify which person _____
- Married? Y◯ N◯ Filing Jointly? Y◯ N◯
- Do you or any family members currently have Medicaid/Medicare/VA coverage? Y◯ N◯
  If yes, please specify the individuals name (s) _____
- If changing jobs, when did you lose coverage? _____
  Open enrollment is November 1st – December 15th if you are applying outside of this period you may qualify For a special enrollment if you lost coverage within the past 60 days.

NOTE: If you currently have Medicaid/Medicare/VA coverage you would not qualify for a Marketplace plan unless you are notified in writing by them that you no longer are eligible and losing the coverage.

Please sign your name here if you have one of these coverages _____