PREMIER ONE
HEALTH INSURANCE YOUR WAY

ACA Intake Form

Employee Contact Information

Name Date Email

Home Address City State Zipcode County

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 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

Would you like for us to look up Doctors or RX? Please provide

Doctor's Full Name

RX Full name and dosage:

SUBMIT ALL INFORMATION TO:
Karen Scherrer
Premier One Administrator
kscherrer@pmgagency.com
260-755-3585 Ext.102
Fax: 260-444-4212