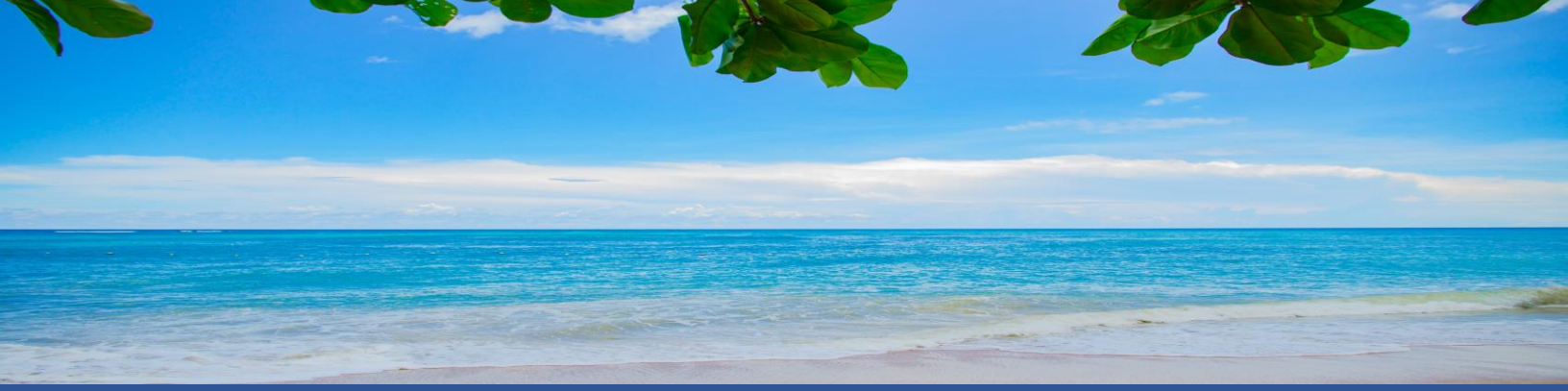

Health Insurance Questionnaire

Household Zip Code: _____ Requested Effective Date: _____/_____/_____

Current Coverage			Proposed Coverage		
Carrier:		Premium:	Carrier:		Premium:
Deductible:	MOOP:	◻ Individual ◻ Group	Deductible:	MOOP:	◻ Individual ◻ Private
Primary:	Specialist:	◻ HMO ◻ PPO ◻ EPO	Primary:	Specialist:	◻ HMO ◻ PPO ◻ EPO

Primary Applicant		
Name:	◻ Male ◻ Female	Applying For Coverage? Y / N
DOB:	Phone:	US Citizen? Y / N ↳ If no, Legal Immigrant? Y / N
Email:		Lived in US for previous 12 months? Y / N
Employer Name:		Tobacco User? Y / N
20+ Employees? Y / N	Employer Phone:	Annual Income:

Spouse		
Name:	◻ Male ◻ Female	Applying For Coverage? Y / N
DOB:	Phone:	US Citizen? Y / N ↳ If no, Legal Immigrant? Y / N
Email:		Lived in US for previous 12 months? Y / N
Employer Name:		Tobacco User? Y / N
20+ Employees? Y / N	Employer Phone:	Annual Income:

Dependent(s)					
Name:	◻ Male ◻ Female	DOB:	Smoker? Y / N	Annual Income:	Applying? Y / N
Name:	◻ Male ◻ Female	DOB:	Smoker? Y / N	Annual Income:	Applying? Y / N
Name:	◻ Male ◻ Female	DOB:	Smoker? Y / N	Annual Income:	Applying? Y / N

Care Providers		
Facility:	Doctor:	◻ Physician ◻ Specialist ◻ Hospital
Facility:	Doctor:	◻ Physician ◻ Specialist ◻ Hospital
Facility:	Doctor:	◻ Physician ◻ Specialist ◻ Hospital

Medications			
Prescription:	Dosage:	Refill Amt:	Refill Freq: ◻ 30 Days ◻ 60 Days ◻ 90 Days
Prescription:	Dosage:	Refill Amt:	Refill Freq: ◻ 30 Days ◻ 60 Days ◻ 90 Days
Prescription:	Dosage:	Refill Amt:	Refill Freq: ◻ 30 Days ◻ 60 Days ◻ 90 Days
Prescription:	Dosage:	Refill Amt:	Refill Freq: ◻ 30 Days ◻ 60 Days ◻ 90 Days

Additional Information Worksheet

Additional Dependent(s)

Name:	□ Male □ Female	DOB:	Smoker? Y / N	Annual Income:	Applying? Y / N
Name:	□ Male □ Female	DOB:	Smoker? Y / N	Annual Income:	Applying? Y / N
Name:	□ Male □ Female	DOB:	Smoker? Y / N	Annual Income:	Applying? Y / N
Name:	□ Male □ Female	DOB:	Smoker? Y / N	Annual Income:	Applying? Y / N
Name:	□ Male □ Female	DOB:	Smoker? Y / N	Annual Income:	Applying? Y / N

Additional Care Providers

Facility:	Doctor:	□ Physician	□ Specialist	□ Hospital
Facility:	Doctor:	□ Physician	□ Specialist	□ Hospital
Facility:	Doctor:	□ Physician	□ Specialist	□ Hospital
Facility:	Doctor:	□ Physician	□ Specialist	□ Hospital
Facility:	Doctor:	□ Physician	□ Specialist	□ Hospital
Facility:	Doctor:	□ Physician	□ Specialist	□ Hospital
Facility:	Doctor:	□ Physician	□ Specialist	□ Hospital
Facility:	Doctor:	□ Physician	□ Specialist	□ Hospital

Additional Medications

Prescription:	Dosage:	Refill Amt:	Refill Freq: □ 30 Days □ 60 Days □ 90 Days
Prescription:	Dosage:	Refill Amt:	Refill Freq: □ 30 Days □ 60 Days □ 90 Days
Prescription:	Dosage:	Refill Amt:	Refill Freq: □ 30 Days □ 60 Days □ 90 Days
Prescription:	Dosage:	Refill Amt:	Refill Freq: □ 30 Days □ 60 Days □ 90 Days
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Prescription:	Dosage:	Refill Amt:	Refill Freq: □ 30 Days □ 60 Days □ 90 Days