Health Insurance Intake Form

Please fill out personal, occupational, and medical information for each member of the household.

Personal Information

Full Name	
Home Address	
Zip Code & County	
Phone Number	
Preferred Email Address	
Birthday (MM/DD/YYYY)	
SSN	
Driver's License Number	
Driver's License Exp Date	

Occupational & Income Information

Company	
Business Address	
Job Title	
Business Phone	
Gross Income	
Adjusted Gross Income	
401(k) Contribution	
IRA Contribution	

Medical Information

Primary Care Providers Name	
Primary Care Providers Phone	
Primary Care Providers Address	
Known Medical History	
Known Food or Drug Allergies	
Medications	

Existing Coverage

Carrier Name		
Monthly Premium		
Annual Deductible		
Annual Max Out of Pocket		
Co-Pays if applicable		
Do you have an HSA? Is it through work?		
Have you applied for Medicaid in the last 90 Days?	☐ **Yes**	☐ **No**
Have you been denied Medicaid in the last year?	☐ **Yes**	☐ **No**

Ancillary Coverage

Please note any additional benefits you would like a quote for.	
Dental	☐
Vision	☐
Life	☐
Short-Term Disability	☐
Long-Term Disability	☐

Printed Name: _____

Signature: _____ Date: _____