Insert Broker logo

Broker Information

Client Name:

County:

CONTACT INFORMATION			
Last Name:	**First Name:**	**Middle Initial:**	**Suffix:**
Marital Status:	**Date of Birth:**	**Gender:**	**Tobacco:**
Email Address:	**Primary Phone:**	**Secondary Phone:**	
Social Security #:			
Address Line 1:	**Address Line 2:**		
Zip Code:	**County:**	**City:**	**State:**
Written Language:	**Spoken Language:**		

GENERAL QUESTIONS	ANSWER
1. I will be applying for coverage for myself	
2. I want to see if I may qualify for lower costs through the Federal Marketplace	
3. Are you a U.S. citizen or U.S. national?	
4. Do you plan to file a federal income tax return for 2020?	
5. Will you be claimed as a dependent on someone else's tax return?	
6. Will you have any income in 2020?	
1. Type of Income:	
Employer Name:	
Amount:	
Frequency:	
7. Do you pay for any of the following deductions: Alimony, Student loan interest or Other?	
8. Did your household income change by more than 7.5% over the past year?	

DEPENDENT			
Filling joint tax return for 2020:			
Last Name:	**First Name:**	**Middle Initial:**	**Suffix:**
Date of Birth:	**Gender:**	**Tobacco:**	
Social Security #:	**Claiming on taxes for 2020:**	**Applying for coverage:**	
Address Line 1:	**Address Line 2:**		
Zip Code:	**County:**	**City:**	**State:**

DEPENDENT'S INCOME INFORMATION	ANSWER
Will this person have income for 2020?	
1. Type of Income:	
Employer Name:	

DEPENDENT'S INCOME INFORMATION	ANSWER
Amount:	
Frequency:	
Does this person pay for any of the following deductions: Alimony, Student loan interest or Other?	

DEPENDENT			
Last Name:	**First Name:**	**Middle Initial:**	**Suffix:**
Date of Birth:	**Gender:**	**Tobacco:**	
Social Security #:	**Claiming on taxes for 2020:**	**Applying for coverage:**	
Address Line 1:	**Address Line 2:**		
Zip Code:	**County:**	**City:**	**State:**

DEPENDENT'S INCOME INFORMATION	ANSWER
Will this person have income for 2020?	
Does this person pay for any of the following deductions: Alimony, Student loan interest or Other?	

DEPENDENT			
Last Name:	**First Name:**	**Middle Initial:**	**Suffix:**
Date of Birth:	**Gender:**	**Tobacco:**	
Social Security #:	**Claiming on taxes for 2020:**	**Applying for coverage:**	
Address Line 1:	**Address Line 2:**		
Zip Code:	**County:**	**City:**	**State:**

DEPENDENT'S INCOME INFORMATION	ANSWER
Will this person have income for 2020?	
Does this person pay for any of the following deductions: Alimony, Student loan interest or Other?	

DEPENDENT			
Last Name:	**First Name:**	**Middle Initial:**	**Suffix:**
Date of Birth:	**Gender:**	**Tobacco:**	
Social Security #:	**Claiming on taxes for 2020:**	**Applying for coverage:**	
Address Line 1:	**Address Line 2:**		
Zip Code:	**County:**	**City:**	**State:**

DEPENDENT'S INCOME INFORMATION	ANSWER
Will this person have income for 2020?	
Does this person pay for any of the following deductions: Alimony, Student loan interest or Other?	

DEPENDENT			
Last Name:	**First Name:**	**Middle Initial:**	**Suffix:**
Date of Birth:	**Gender:**	**Tobacco:**	
Social Security #:	**Claiming on taxes for 2020:**	**Applying for coverage:**	

DEPENDENT			
Address Line 1:	**Address Line 2:**		
Zip Code:	**County:**	**City:**	**State:**

DEPENDENT'S INCOME INFORMATION	ANSWER
Will this person have income for 2020?	
Does this person pay for any of the following deductions: Alimony, Student loan interest or Other?	

ELIGIBILITY QUESTIONS	ANSWER
1. Were any of these people found not eligible to get Medicaid or Children's Health Insurance Program (CHIP) in the past 90 days? Or, were any of them found not eligible for Medicaid or CHIP due to their immigration status since October 1, 2013?	
2. Are you or any of your dependents American Indian or Alaskan Native?	
3. Are you or any of your dependents enrolled in other health coverage?	
4. Are you or any of your dependents currently eligible for group coverage, including COBRA?	
5. Will you or any of your dependents be eligible for group coverage in 2020, including COBRA?	

OPTIONAL QUESTIONS	ANSWER
1. Did you or any of your dependents recently lose health coverage?	
2. Are you or any of your dependents losing health coverage in the next 60 days?	
3. Did you or any of your dependents recently get married?	
4. Have you or any of your dependents recently been adopted, placed for adoption or placed for foster care?	
5. Have you or any of your dependents recently gained eligible immigration status?	
6. Have you or any of your dependents recently moved?	
7. Have you or any of your dependents been recently released from incarceration?	

ADDITIONAL COMMENTS

Medical Providers

Name	Provider Type	City	State

Prescriptions

Name	Dosage	Frequency

Tax Questions	Anwers
How will you file your tax return for 2020?	
Will you claim any dependents that are not listed on this form on your taxes? If yes, how many?	

Questions	Answers
I understand that will complete my health plan application and if, chosen by me, provide my financial information on my behalf to determine if I am eligible to purchase plans on the Federal Marketplace.	
No one applying for health coverage on this application is incarcerated (detained or jailed).	
To make it easier to determine my eligibility for help paying for health coverage in furture years, I agree to allow the Marketplace to use income data, including information from tax returns, for the next 5 years (the maximum number of years allowed). The Marketplace will send me a notice, let me make any changes, and I can opt out at any time.	
I know that I must tell the program I'll be enrolled in if information I list on this application changes. I know I can make changes in my Marketplace account or by calling 1-800-318-2596. TTY users should call 1-855-889-4325. I understand that a change in my information could affect my eligibility for member(s) of my household.	
I understand that if I qualify for a premium tax credit that I must file a tax return for 2020 and, if married I will need to file a joint tax return.	

HIPPA Authorization

I give the agent list on this form authorization to complete the enrollment . Please refer to the complete HIPPA authorization form that has been completed.

Privacy Notice

Initial & Date

Please visit https://www.healthcare.gov/privacy/ to view details on the privacy policy.

Discoluse and Consent Agreement: By consenting to this agreement, I am giving my consent to use the confidential information on this form that I have provided by phone and/or on this document only for the purposes of determining eligibility for healthcare coverage subsidy, enrollment in healthcare or other insurance plans. I give my permission for the above mentioned entities/persons to contact me for the purposes of further determining eligibility, educating me on health and other insurance options and/or setting an appointment or means to review and/or sign an application for insurance. I understand that no confidential/private information will be shared with any outside entity other than those described above.

Date: _______________ Time: ___________________ Location: ___________________

Print Name: ____