Health Application

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For Office Use Only

Agent Name/ID#: _____ FFM User Name: _____

NPN#: _____ Email: _____ Application ID#: _____

MP User Name: _____ MP Password: _____ Premium: $_____

Tax Credit: $ _____ = Net Premium: $ _____ Annual Premium: $_____

Plan: ☐ Bronze ☐ Silver ☐ Gold ☐ Platinum Deductible: $ _____ MOOP: $ _____ CoPay: $ _____

On or Off Exchange: (On ☐ or Off ☐) Additional Coverages: ☐ Dental/Vision ☐ Critical Illness ☐ Hospital ☐ Indemnity

☐ Life ☐ Cancer ☐ Accident ☐ Disability Income ☐ Annuities ☐ Long Term Care ☐ Medicare ☐ Employee Benefits

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Primary

Address: _____ City: _____ State: _____ Zip: _____

Name: _____ Last Name: _____ Phone: _____

Cell: _____ Do you smoke (Y ☐ or N ☐) Any known illnesses (Y ☐ or N ☐) if yes list below

Place of Employment: _____ Filing Taxes Next Year (Y ☐ or N ☐ if yes Married ☐ or Single ☐

Gender: ☐ Male ☐ Female Date of Birth: _____/_____/_____ Email: _____

*Gross Annual Household Income: _____. Total Family Size: _____.

Spouse

Name: _____ Last Name: _____ Phone: _____

Cell: _____ Do you smoke (Y ☐ or N ☐) Any known illnesses (Y ☐ or N ☐)if yes list below

Place of Employment: _____ Filing Taxes Next Year (Y ☐ or N ☐) if yes Married ☐ or Single ☐

Gender: ☐ Male ☐ Female Date of Birth: _____/_____/_____ Email: _____

Dependents /Children list all kn own illnesses in the comments area.

First , Last Name	M/F	Relationship	DOB	SSN#	Tabacco/Smoke	Covered
					Y ☐ or N ☐	Y ☐ or N ☐
					Y ☐ or N ☐	Y ☐ or N ☐
					Y ☐ or N ☐	Y ☐ or N ☐
					Y ☐ or N ☐	Y ☐ or N ☐
					Y ☐ or N ☐	Y ☐ or N ☐

Comments or Description Illnesses: