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Health Insurance Enrollment Form

A. Client Information

Name: (As it appears on your social security card)

DOB: Social Security #:

Tobacco/Non-Tobacco: Marital status:

Address: City: Zip:

Phone: County:

E-mail:

B. Name of Employer and Employers Phone Number for each:

1. Primary Insured -
2. Spouse -

C. Total *Projected Household* Income for 2022 (Gross) ?

(List all household income including social security and retirement plan withdrawals)

1. Primary Insureds portion of household income *(list amount and source)* -
2. Spouses portion of household income *(list amount and source)* -

*(list name and DOB of spouse and dependents even if they're not applying)

Spouse

Applying for insurance: yes / no

Name:

DOB: Tobacco / NT

Social Security #:

Dependent 1

Applying for insurance: yes / no

Name:

DOB:

Social Security #:

Additional:

Dependent 2

Apply for insurance: yes / no

Name: _____

DOB: _____

Social Security #: _____

Dependent 3

Apply for insurance: yes / no

Name: _____

DOB: _____

Social Security #: _____

Dependent 4

Apply for insurance: yes / no

Name: _____

DOB: _____

Social Security #: _____

Dependent 5

Apply for insurance: yes / no

Name: _____

DOB: _____

Social Security #: _____