Individual Health Insurance Fact Finder

Applicant Information

Last Name____ First Name_________________________ MI____

Street Address____

Phone ___________________________ Email ____

You may be eligible for a tax subsidy. Are you interested in determining your eligibility? Yes / No

Applicant & Dependent Information

SSN	Name (Last, First, MI)	US Citizen (Y/N)	DOB (MM/DD/YY)	Gender (M/F)	Tobacco (Y/N)
Applicant					
Spouse					
Dependent					
Dependent					
Dependent					

OTHER: Are there any other members in the household not listed above (incl. parents/grandparents/roommates, etc, even if they are not going to be covered under this policy)? Y / N If yes, how many? ________________________

List including relationship: ____

Employer Information

Applicant's Employer: ____

Is group health insurance offered at the Applicant's place of employment? Y / N

Spouse's Employer: ____

Is the Applicant's spouse eligible for group health insurance at his/her place of employment? Y / N

Dependent's Employer: ____

Are any Dependents eligible for group health insurance at their place of employment? Y / N

Annual Household Income

Applicant's estimated annual gross income: ________________ Spouse's estimated annual gross income: _______________

Do you file Single? Married? or Married, filing at Single rate? _____________ # of dependents claimed on your return_________

Any additional Household income (for dependents or household members even if not included on the application for coverage) ? If yes, list income(s) and source(s) ____