INDIVIDUAL HEALTH FORM

Elite Insurance Associates – Email: ClientServices@eiafl.com

Preferred Agent (Optional): _____

PRIMARY APPLICANTS GENERAL INFORMATION

First Name: _____ MI: ____ Last Name: _____

Social Security #: _____ Age: _____ DOB: _____ Gender: _____

Home Address: _____ City: _____ County: _____ State: _____ Zip: _____

Phone Numbers: Primary: _____ Secondary: _____

E-mail Address: _____ Tobacco Usage: ☐ YES ☐ NO

Married? ☐ YES ☐ NO Filing Jointly? ☐ YES ☐ NO Total number of people in **taxable** household: _____

If you are married and applying for a tax subsidy, you MUST file a joint income tax return.

TAXABLE HOUSEHOLD INCOME

Primary Applicants Annual Income:

_____

Source of Income/ Name of Employer:

_____

Phone Number for Employer:

_____

Spouses' Annual Income:

_____

Spouses' Source of Income/ Name of Employer:

_____

Phone Number for Spouses' Employer:

_____

GROUP COVERAGE INFORMATION

Is anyone eligible for Group Insurance? ☐ YES ☐ NO

Are you losing Group Insurance? ☐ YES ☐ NO

If so, when? _____

If eligible for group coverage, please have your rates from your employer for all coverage levels available to determine eligibility for a tax credit.

LIST ANYONE IN YOUR TAXABLE HOUSEHOLD YOU FILE A JOINT INCOME TAX RETURN WITH OR CLAIM AS A DEPENDENT EVEN IF COVERAGE IS NOT NEEDED:

Last Name:	First Name:	MI:	SSN:	Gender:	DOB:	Relationship:	Tobacco Usage?	Are we applying for Coverage?
Spouse								
Child								
Child								
Child								
Child								

INDIVIDUAL HEALTH FORM

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Primary Applicant
Last Name: _____

First Name: _____

IF YOU ARE INTERESTED IN DETERMINING IF YOUR CURRENT PHYSICIANS, HOSPITALS, AND MEDICATIONS ARE COVERED, PLEASE LIST THEM BELOW:

Primary Care Physician:

_____

Specialist:

_____

Specialist:

_____

Preferred Hospital:

_____

Pediatric Physician:

_____

Specialist:

_____

Specialist:

_____

Preferred Pediatric Hospital:

_____

Medications Name: _____
Dose: _____
How Often Taken: _____

Medications Name: _____
Dose: _____
How Often Taken: _____

Medications Name: _____
Dose: _____
How Often Taken: _____

Medications Name: _____
Dose: _____
How Often Taken: _____

DO YOU NEED DENTAL AND VISION?

Preferred Dentists Office:

_____

Preferred Dentists First and Last Name:

_____

Preferred Eye Doctors Office:

_____

Preferred Eye Doctors First and Last Name:

_____

Please Note: The information contained in this form should match your IRS tax filing, this information is required to determine eligibility for an advanced premium tax credit.