



Member Name:	Phone:	
Street Address:	City:	Zip:
County:	Email:	

Member Name <i>Please include yourself below</i>	Relationship <i>Self, Spouse, or child?</i>	DOB	AGE	Gender	Height & Weight	Tobacco <i>Yes or No?</i>	Applying for Coverage?

Current Plan Information

- Who is your current insurance carrier?
- How much do you pay?
- How much is your deductible?
- Do you have copays for office visits or drugs?
- Is everyone in the household insured on this plan?
 - o *If not, who isn't?*
 - o *And why?*
- Do you have your own individual plan, or did you get this through your employer?
 - o *If employer, do you know your employee only rate?*
- Does an employer offer anyone in your household health insurance?

- Are there any benefits you wish you had that you do not have now?

- Do you have any upcoming tests or procedures that you are concerned about and want to make sure are covered?

- Does anyone currently have an existing medical condition you think may cause a surgery or hospitalization within the next 2 years?

- Is anyone currently pregnant, expecting to have kids, or see this as a risk of happening in the next 2 years?

- Do you currently take any drugs?
 - o *Get name & dosage*
 - o *Make sure to get the generic name if taking a generic, many times members will say the brand name because they don't know how to pronounce the generic.*

- Are there any doctors you want to keep in network?
 - o *Get name & either phone or street name*
 - o *If several doctors are provided, find out which ones they could live without, and which ones are must haves.*

- Do you have a preferred hospital you wish to keep in network?

- Income
 - o Primary Member:
 - o Spouse:
 - o Dependent children:

Additional Notes: