Individual
Health Solutions

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Insurance Questionnaire

Contact Information

Date:

First Name:

Last Name:

Email:

Phone:

Address:

City: State: Zip:

Insurance Needed

Check all that apply

- Individual/Family Health Insurance *(Marketplace & Non-Marketplace)*
- Medicare Plans
- Dental Insurance
- Vision Insurance
- Life Insurance
- Disability Insurance
- Travel Insurance

Required Information to Quote

(Note if you have more than 4 children, provide additional information in the comments field at the end of this form)

Family Members Names	Gender	Date of Birth	Tobacco Use
Primary	M F		Yes No
Spouse	M F		Yes No
Child 1	M F		Yes No
Child 2	M F		Yes No
Child 3	M F		Yes No
Child 4	M F		Yes No

Do you currently have Health Insurance?	Yes No	Company Name:
Do you &/or spouse have Health Insurance available through an employer?	Yes No	Employer Name:

Preferred Doctors, Hospitals, etc.

Family Size *(to determine your subsidy eligibility)* Household Income $

Comments