



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	
	M	F		Yes	No
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: _____

Provider Network Preferred Ascension Aurora Health Care Children's Hospital & Health System Froedtert & the Medical College of WI ProHealth Care

Family Size *(to determine your subsidy eligibility)* Household Adjusted Gross Income (AGI) \$ _____

Comments _____