Request for Individual Health Insurance

This form is for employees and/or employee dependents looking for individual health insurance coverage only; not to be used for employer or PEO sponsored group plans (i.e. Vision, Dental, Life, etc.)

To be completed by Employee (All fields required for quote)

Name (Last, First, MI)____

Street Address ____

City, State, Zip ____

Email Address ____

Phone Number ____

If you think you may qualify for a subsidy or premium tax credit please provide the following:

Estimated 2017 Income ______________ Number of Dependents Living in your Household ____________________

Please provide following information on you, spouse and/or any dependents you wish to cover on your policy.

Name	Date of Birth	Relationship	Gender	Tobacco Use
			☐ Male ☐ Female	☐ Yes ☐ No
			☐ Male ☐ Female	☐ Yes ☐ No
			☐ Male ☐ Female	☐ Yes ☐ No
			☐ Male ☐ Female	☐ Yes ☐ No
			☐ Male ☐ Female	☐ Yes ☐ No
			☐ Male ☐ Female	☐ Yes ☐ No
			☐ Male ☐ Female	☐ Yes ☐ No

I understand and acknowledge that the information provided is strictly used for the purposes of obtaining and providing individual health insurance options; options provided by licensed insurance agents. I attest that the information provided is true and accurate.

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Employee Signature Date

Please fax this form to Choice HR at 813-643-4441