



Insurance Questionnaire

CONTACT INFORMATION

Date: _____

First Name: _____

Last Name: _____

Email: _____

Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

County: _____

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 Company Name:
No

If No, what was the last day you had credible health insurance?

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

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

Family Size *(to determine your subsidy eligibility)* Household Adjusted Gross Income (AGI) \$
(for the year in which you are requesting coverage)

Comments

I authorize the above-named broker to assist me with reviewing options and potentially obtaining health insurance through the Federal Marketplace **healthcare.gov**. I understand this grants permission to this broker to make changes to my **healthcare.gov** application on my behalf and at my direction. Permission can be rescinded at any time by submitting a request to my agent in writing. Permission will be rescinded on the date of the request.