Individual Health Solutions

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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
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:

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 ◯ No ◯ Employer Name:

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 Individual Health Solutions 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 Permission can be rescinded at any time by submitting a request to my agent in writing. Permission will be rescinded on the date of the request.