PLEASE PRINT CLEARLY Today's Date: _____ County: _____

How many people do you claim on your taxes? _____ How many people need insurance? _____ Did you previously have insurance in 2022? _____

AFFORDABLE CARE ACT CLIENT INFORMATION

NAME AND RELATION TO APPLICANT	M/F	DOB	SSN	APPLYING FOR INSURANCE (Y/N)	TOBACCO (Y/N)	CITIZENSHIP (Y/N)	MEDICAID/ CHIP
1 - Applicant							
2 - Secondary							
Dependent #1:							
Dependent #2:							
Dependent #3:							
Dependent #4:							

Home Address: _____ Mailing Address: _____

City/State/Zip: _____ City/State/Zip: _____

Email: _____ Phone Number: _____

Est 2023 Modified Adjusted Gross Income: _____

Primary's Employer Name: _____ Secondary's Employer Name: _____

Employer Address: _____ Employer Address: _____

Employer Phone: _____ Employer Phone: _____

Misc: Rx and Doctors

X_____

Office Use Only
Plan Name:
Tax Credit:
Plan Premium:
Carrier:
Start Date:
AOR: