You must have Adobe Reader 8 or later to fill this on your computer.
Once you fill it out, please save the file to your computer.
Then email it back to us as an attachment or you can print and mail it back.

Individual & Family Insurance

TODAY'S DATE: _____

Legal First Name:_____ **Middle Initial:** _____ **Last Name:** _____

Nickname: _____ **Check One:** ☐ Married ☐ Single ☐ Widowed ☐ Domestic Partnership

Your Date of Birth:_____ **Your Social Security #:** _____

Spouse's Legal First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Spouse's Date of Birth:_____ **Spouse's Social Security #:** _____

Is anyone a regular tobacco user? Yes ◯ No ◯ If so, who? _____

Home Phone #:_____ **Your Mobile #:**_____ **Spouse Mobile #:** _____

Your Street Address: _____

Apt or Suite:_____ **City:** _____

State: _____ Zip **code:** _____ **County:** _____

Main Email Address: _____

Estimated Annual Adjusted Gross Income for* ENTIRE *household the year of coverage needed: _____

Number of Children you will be claiming on your tax form: _____

If enrolling child(ren), we will need their Social Security #(s).

What is the best way for you to receive our bi-yearly newsletter by email or postal mail? _____

Would you like us to text you your appointment reminders? ◯ Yes ◯ No

What is your preferred form of communication - phone, text or email? _____

Whom may we thank for sending you here? (How did you hear about us?) _____

What medical network do you most frequently use for doctor visits? (Prevea, Aurora, Froedtert , etc) _____

Do you want/need an HSA Plan: Yes ◯ **No** ◯ **Would you like info on Dental and/or Vision Insurance: Yes** ◯ **No** ◯

Information on Life Insurance: Yes ◯ **No** ◯ **Information on Long Term Care: Yes** ◯ **No** ◯

Information on Travel Insurance: Yes ◯ **No** ◯

Any other information you would like the agent to know such as brand prescriptions, c-pap machine, a specific doctor you need covered, etc…:

Names of dependents and birth dates _____

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Or you can print and mail it back.

Name_____ Date _____

IF YOU HAVE MORE THAN 3 GENERIC MEDS or 1 EXPENSIVE MED OR MORE

PLEASE FILL OUT AND RETURN RETURN WITH OTHER DOCUMENTATION BEFORE YOUR MEETING

Medications and Dosages

(Please list all prescription medications you are currently taking)

Medication Name	Medication Dosage	**Amount Per Day**

Do you currently use coupons for medications? ☐ Yes ☐ No

Enter an additional notes here for the agent to review.