Please fill out this attached Two Page form and return it to our office.

This form is fillable, to be completed on your computer, saved, and attached to an email back to me. Or, you can print it, fill it in, and fax or mail it to my office. Additionally you may take a photo with your smart phone or tablet and attach the photo to your email.

I will use this information to start the application process, verify any possible tax subsidy, and preview plan pricing prior to our appointment. You may get emails or letters in the mail from the Health Insurance Marketplace as a result of this preliminary work.

You can rest assured, I will not enroll you in any plans without your authorization. If you have any questions about this process please feel free to contact me.


P: 989-631-1920 • F: 989-631-0003 • TOLL FREE: 1-888-299-1149
2816 JEFFERSON AVE., MIDLAND, MI 48640
Kari Santos karis@arburyins.com • Corinne Provoast corinnep@arburyins.com

# ARBURY INSURANCE AGENCY

***Prequalification Application – Individual Health Insurance***

Name (as on DL/SS cards): ____________ ____________ DOB: ___/___/___ SSN: _____ - ____ - ______ Smoker (Y/N): __

County: ___________ Address: ______________________ City: ____________ State: _______ Zip Code: _________

**Phone Number**: _____- _____ - _______ **Email Address:** _____________________________

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**Please enter in all immediate family members regardless of whether they are electing coverage**

**Spouse Name** __________ _________ DOB: ___/___/_____ **SSN**: ____ - ___- _______ **Gender**: ____ **Smoker**: ___

**Child 1 Name** __________ _________ DOB: ___/___/_____ **SSN**: ____ - ___- _______ **Gender**: ____ **Smoker**: ___

**Child 2 Name** __________ _________ DOB: ___/___/_____ **SSN**: ____ - ___- _______ **Gender**: ____ **Smoker**: ___

**Child 3 Name** __________ _________ DOB: ___/___/_____ **SSN**: ____ - ___- _______ **Gender**: ____ **Smoker**: ___

**Child 4 Name** __________ _________ DOB: ___/___/_____ **SSN**: ____ - ___- _______ **Gender**: ____ **Smoker**: ___

**Answer the following questions by checking "Yes" or "No"**

| | | YES | NO |
|---|---|---|---|
| 1. | Are all individuals applying for coverage legal US Citizens/Residents? | ___ | ___ |
| 2. | Are any family members American Indian or Alaska Natives? | ___ | ___ |
| 3. | Are you currently employed working over 30 hours per week | ___ | ___ |
| 4. | Are you eligible for group health coverage through your employer or spouse's employer? | ___ | ___ |
| 5. | If married, do you file your taxes jointly with your spouse? | ___ | ___ |

6. Please enter your **approx 2019 Adjusted Gross Income (AGI) for entire household** $____________

Please list Employers and Yearly Income, per person:

You: ________________________________________ Spouse: _______________________________________

Children (by name): __________________________________________________________________________

Please create a Marketplace Login, at https://www.healthcare.gov/create-account

Or, verifiy your Account, at https://www.healthcare.gov/login

USERID: ______________________ (email?) Password: _________________

**PLEASE SEND THIS COMPLETED FORM TO Arbury Insurance**

Note: Prospective client information will be kept in strict confidence per the HIPPA regulations and all applicable insurance institution privacy laws.

*The Service you Deserve... Expertise You can Trust.*

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## *Prequalification Application – Health Insurance Marketplace Disclosure*

By signing this form, physically or electronically, you agree to the following statements.

- I have provided true answers to all of the questions to the best of my knowledge. I know I may be subject to penalties under federal law if I intentionally provide false information.
- If my Marketplace Eligibility Notice tells me to send more information, I will follow the instructions by the deadline. If I don't, I could lose what insurance I qualify for now. I may not be able to enroll in a Marketplace plan until the next Open Enrollment Period, in November 2019.
- I know I must tell the Marketplace if information I listed on this application changes. I know I can make changes in my Marketplace account online or by calling 1-800-318-2596. I know a change in my information could affect eligibility for member(s) of my household.
- If my insurance is cancelled due to nonpayment, I won't be able to enroll in a Marketplace plan until the next Open Enrollment Period, in November 2019.
- I understand when I file my tax return; the IRS will compare the income on my tax return with the income on my application. If my income is higher than reported, I may owe additional federal income taxes.
- I will file a federal income tax return next year, for this year. If I am married, I will file joint with my spouse. No one else will claim me as a dependent.
- I will claim a personal exemption deduction on my federal income tax return for any individuals listed on the application as a dependent who is enrolled in coverage through the Marketplace.

**Applicant Signature** _______________________________________________ **Date** ___/___/_____

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## *Prequalification Application – Acknowledgement to Review Notice of Privacy Practices*

I was notified that I can view at www.arburyins.com/privacy

I understand that I may request a paper or electronic copy at any time.

**Applicant Signature** _______________________________________________ **Date** ___/___/_____

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**Prequalification Application Authorization – Signature Required (physical or electronic)**

My signature below indicates that I understand, and provide my consent, to have **Arbury Insurance** evaluate different individual health insurance options on my behalf. I provide my consent and allow **Arbury Insurance** to use information contained on this form to execute an enrollment on my behalf based on the plan I verbally select with my agent. I declare that the answers and information presented on this application are complete and true for all applicants to the best of my knowledge and belief, and will be used as the basis for issuing coverage and determining my eligibility for an "Advanced Premium Tax Credit" (APTC) from the Health Insurance Marketplace. I understand that I should not cancel any current coverage I currently have in place until I receive written notice of approval from **Arbury Insurance**. I understand that any person who, knowingly and with intent to defraud any insurance company or other governmental entity, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act when determined by a court of competent jurisdiction, and as such may be subject to criminal and civil penalties. I understand that this coverage is not an employer group health plan and is not intended to be an employer-sponsored health insurance plan. I certify that my employer will not contribute any funds toward the cost of this coverage.

**Applicant Signature** _______________________________________________ **Date** ___/___/_____

**PLEASE SEND THIS COMPLETED FORM TO Arbury Insurance**

Note: Prospective client information will be kept in strict confidence per the HIPPA regulations and all applicable insurance institution privacy laws.



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