AFFORDABLE CARE ACT APPLICATION

PREMIUN ESTIMATE $ _____

SUBSIDY ESTIMATE $ _____

INSURANCE COMPANY_____

PLAN NAME_____

_____

NAME _____

EMAIL ADDRESS _____

PHONE NUMBER (_____) _____

APP **ADDRESS** _____

DEP _____

_____

DATE OF BIRTH _____ **SEX** _____

SOCIAL SECURITY _____

FILING STATUS: single _____ married _____

INCOME $ _____

EMPLOYER NAME _____

EMPLOYER NUMBER (_____) _____

IMMIGRATION STATUS _____

ALIEN # _____

NATURALIZACION CERTF. # _____

GREEN CARD # _____

SPOUSE NAME _____

SPOUSE D.O.B _____ SEX _____

SPOUSE S.S.N _____

SPOUSE INCOME $ _____ **APP**

SPOUSE EMPLOYER NAME _____ **DEP**

SPOUSE EMPLOYER NUMBER (_____) _____

SPOUSE IMMIGRATION STATUS _____

SPOUSE ALIEN # _____

SPOUSE NATURALIZATION CERTF. _____

SPOUSE GREEN CARD #_____

HOUSEHOLD INCOME $_____

NOTES: _____

_____

_____

_____

DEPENDENTS

APP **NAME** _____ SEX ____ **NAME** _____ SEX ____ **APP**

DEP D.O.B _____ S.S.N _____ D.O.B _____ S.S.N _____ **DEP**

NAME _____ **NAME** _____

APP D.O.B _____ S.S.N _____ D.O.B _____ S.S.N _____ **APP**

DEP SEX _____ INCOME _____ A# _____ SEX _____ INCOME _____ A# _____ **DEP**

EMPLOYER NAME _____ EMPLOYER NAME _____

EMPLOYER NUMBER (_____) _____ EMPLOYER NUMBER (_____) _____

PAYMENTS NAME ON ACCOUNT _____ BANK NAME _____

ACCOUNT NUMBER _____ ROUTING NUMBER _____

PAYMENT C. CARD INFO _____ TYPE _____ EXP _____ SEC. CODE _____

ACCOUNT ADDRESS SAME DIFFERENT _____

APPLICANT SIGNATURE _____ **DATE**_____