ACA Pre-Enrollment Questionnaire

STEP 1 TELL US ABOUT YOURSELF

First Name, Middle Name, Last Name, Suffix

Home Address			Apartment Number
City	State	Zip Code	County

Phone Number	Alternate Phone Number

Email address:

Preferred spoken or written language:

Date of Birth (mm/dd/yyyy)	Sex ☐ Male ☐ Female

Social Security Number ________ - ______ - _________

Do you smoke? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No

Are you a U.S. Citizen or U.S. National? ☐ Yes ☐ No ☐ Work Authorization ☐ Green Card ☐ Alien Registration Number_______________

Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? ☐ Yes ☐ No

STEP 2 CURRENT JOB & INCOME INFORMATION

☐ Employed ☐ Self Employed ☐ Not Employed ☐ Married ☐ Single

Total Household Income for 2014 ________________________ ☐ File Jointly ☐ Dependants

Total Household Estimated Income for 2015 ________________________

Do you have a monthly budget established for health insurance? ☐ Yes ☐ No

Do you have a checking account? ☐ Yes ☐ No

STEP 3 TELL US ABOUT YOUR FAMILY

Spouse (Additional Insured's)

First Name, Middle Name, Last Name, Suffix

Relationship to you?

Date of Birth (mm/dd/yyyy)

Sex
☐ Male ☐ Female

Social Security Number ________ - ______ - _________
We need this if you want health coverage and have a SSN

Do they smoke? ☐ Yes ☐ No

Dependent 1

First Name, Middle Name, Last Name, Suffix

Relationship to you?

Date of Birth (mm/dd/yyyy)

Sex
☐ Male ☐ Female

Social Security Number ________ - ______ - _________
We need this if you want health coverage and have a SSN

Do they smoke? ☐ Yes ☐ No

Dependent 2

First Name, Middle Name, Last Name, Suffix

Relationship to you?

Date of Birth (mm/dd/yyyy)

Sex
☐ Male ☐ Female

Social Security Number ________ - ______ - _________
We need this if you want health coverage and have a SSN

Do they smoke? ☐ Yes ☐ No

Dependent 3

First Name, Middle Name, Last Name, Suffix

Relationship to you?

Date of Birth (mm/dd/yyyy)

Sex
☐ Male ☐ Female

Social Security Number ________ - ______ - _________
We need this if you want health coverage and have a SSN

Do they smoke? ☐ Yes ☐ No

STEP 4

Are you or your family enrolled in health coverage now?

☐ Yes If yes, check which coverage you have ☐ No

☐ Individual ☐ Medicaid ☐ Florida KidCare ☐ Covered Through Your Job

SIGNATURE

ACKNOWLEDGEMENT OF PPACA ENROLLMENT ASSISTANCE

Regions Health Group DBA Compass Health Insurance utilizes health insurance agents licensed in the state of Florida and certified by CMS to assist potential clients in the enrollment process through www.healthcare.gov.

In seeking assistance, I understand and agree that:

- All information supplied regarding household income, marital status, citizenship status and all other questions/answers are accurate to the best of my knowledge.
- If proof of income is required by the Marketplace, neither RHG nor its agents are responsible, required to assist or advise you in preparation of proof.
- If any changes occur to the information provided at the time of enrollment, I agree to contact the Marketplace to make corrections as a change could affect eligibility/status for member(s) of my household.
- Personal information is only used to determine eligibility in purchasing a health plan and will be kept private in accordance with the law.

______________________________	______________________________	____________
Print Name	Signature	Date
______________________________	______________________________	____________
Agent of Record PRINT	Signature	Date

Regions Health Group DBA Compass Health Insurance does not discriminate on the basis of race, color, sex, age, sexual orientation, national origin, gender identity, or disability.

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