BEATRICE
INSURANCE
Life Happens. Be Prepared.

The answers to the following will allow us to determine Health insurance subsidy eligibility and to advise the best insurance carrier for you, your family and your specific situation and health insurance needs.

NAME:			**PHONE #:**
DATE OF BIRTH:	**EMPLOYER:**		
GENDER: M/F	**SMOKING STATUS: Y/N**	**EMPLOYER COVERAGE: Y/N**	**HOUSEHOLD INCOME:**
ADDRESS:			
CITY:	**STATE:**	**ZIP CODE:**	**COUNTY:**
EMAIL ADDRESS:			
SS#	**Race:**		**Hispanic: Y/N**
Ethnicity	**US Citizen: Y/N**		**Other:**

HOUSEHOLD INFORMATION:

	NAME	DATE OF BIRTH	GENDER	SMOKING STATUS
SPOUSE			**M/F**	**Y/N**
DEPENDENT 1			**M/F**	**Y/N**
DEPENDENT 2			**M/F**	**Y/N**
DEPENDENT 3			**M/F**	**Y/N**
DEPENDENT 4			**M/F**	**Y/N**
DEPENDENT 5			**M/F**	**Y/N**

PROVIDER INFORMATION

	NAME	SPECIALTY	CONTACT INFO
PROVIDER 1			
PROVIDER 2			
PROVIDER 3			
PROVIDER 4			
PROVIDER 5			

MEDICATION INFORMATION

	NAME	DOSE	FREQUENCY
Rx 1			
Rx 2			
Rx 3			
Rx 4			
Rx 5			

HOSPITAL INFORMATION

Is there a specific hospital(s) that you would like to have in-network? Please List.

Are you willing to change providers? **Y/N**

(Similarily, if you have a provider(s) that you would prefer not to change, please indicate.

Beatrice Inurance Agency
P.O. Box 105
Union, KY 41091
www.beatriceinsuranceagency.com
859-918-6720