Healthcare Intake Summary

❑ Health Insurance

Date: _____

Agent Name: _____

CLIENT INFORMATION

	First Name	Last Name	DOB	SSN #	Tobacco Use
Primary					
Spouse					

Current Mailing Address _____

City _____ State _____ Zip Code_____ County _____

Phone # 1 _____ Phone # 1 _____

Email Address _____

Persons whom you are claiming on your income tax return

Relationship	First Name	Last Name	DOB	SSN #	Need Healthcare Coverage?

Projected Yearly Income: (Primary) _____ (Spouse) _____

Do you have Health Coverage provided by your Employer? (Primary) ❑Yes ❑ No (Spouse) ❑Yes ❑ No

Employer Name: _____ Phone: _____

Employer Name: _____ Phone: _____

Current Healthcare Provider: _____ Effective Coverage Dates: _____

Current Healthcare Provider: _____ Effective Coverage Dates: _____

Supplemental Coverage Desired (Check all that apply) ❑ Dental ❑Vision

❑ Accident ❑ Critical Illness Insurance ❑ Life Insurance

Intake Notes:_____

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