Under 65 Health Insurance Worksheet

Name: ____Phone #: _______________

Spouse Name: _______________________________________ Phone #: ________________

Address: ____

E-Mail Address: ____ County: _____________

Anticipated Total Household Income for Current Year: ________________ Ok to Text: ________

Is Employer Coverage Available: _______________ # of people in household: _____________

Dental Coverage Desired: ______ Vision Coverage Desired: ______ Life Insurance Desired: _____

Please list all household members and mark accordingly if coverage is desired for that person:

Name	Birthdate	Social Security #	Tobacco	Coverage Needed	Pre-Existing Conditions

Do you or any of your family members have specific needs for this year such as surgeries, dental work, etc: ____

____

Primary Care Physician & Specialists (list all doctors): _________________________________

____

____

____

Preferred Hospital: _________________________ Preferred Pharmacy: ________________

Do you travel frequently: __________________ Do you travel outside of the U.S.: ___________

Christina McGinley
McGinley Insurance Agency, Inc.
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Call/Text: (812) 758-7355
Fax: (812) 304-4965
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www.mcginleyinsurance.com

Please provide a clear list of all your prescription medications:

Drug: ______________________________ Dosage: ____________ # Daily: ______

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Drug: ______________________________ Dosage: ____________ # Daily: ______

Drug: ______________________________ Dosage: ____________ # Daily: ______

Drug: ______________________________ Dosage: ____________ # Daily: ______

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Drug: ______________________________ Dosage: ____________ # Daily: ______

Drug: ______________________________ Dosage: ____________ # Daily: ______

Drug: ______________________________ Dosage: ____________ # Daily: ______

Additional Doctors/Optometrist/Dentist/Specialists/Special Needs or concerns:

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I take your private health information seriously but in order to advise you if your doctors are in network and your drugs are covered, I must have the above questions answered. I will not share your information with anyone expect the insurance company that you apply for coverage with. By signing below, you acknowledge and give your consent to McGinley Insurance Agency, Inc. to assist you with a Marketplace and/or other Health Insurance products. This includes permission to conduct an online person search within the Marketplace System (healthcare.gov), assisting and completing an eligibility application, plan selection, enrollment, as well as annual reviews.

____ ______________

Primary Applicants Signature Date

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