PRE-QUALIFICATION NEW FORM

YEAR _____

Personal Information

Application ID# _____ Today's Date _____/_____/_____

Email_____ @_____Mobile Number (_____) _____ - _____

First Name _____ Middle name _____

Last Name _____ Race _____ (Optional)

SSN _____-_____-_____ Date of Birth _____/_____/_____Sex M____ F ____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____

Street _____City _____ State _____ Zip _____

Immigration Status (check what apply)

US Citizen ○ Green card ○ TPS ○

Card #_____ EXP date _____ A #_____ Category_____

Relationship /Tax / Employment

Married ○ Single ○ Dependents ○ How many _____ how do you file tax? Separated ○ Jointly ○ Dependent Yes ○ No ○

Are You Currently Working? Yes ____ No ____ Self Employed _____ Unemployed _____ SSI_____ Amount $ _____/mo.

Spouse Information

First Name _____ Last name _____ D.O.B _____/_____/_____

SSN: _____-_____-_____ US Citizens ____ Green card _____ TPS _____

Card #_____ EXP date_____ A#_____ Category _____

Dependents Information

1-Full Name _____ D.O.B ____/_____/_____ SSN _____-_____- _____RELATIONSHIP_____

US Citizen ○ Green card ○ TPS ○ Card #_____ EXP date _____ Category_____

2-Full Name _____ D.O.B ____/_____/_____ SSN _____-_____-_____ RELATIONSHIP_____

US Citizen ○ Green card ○ TPS ○ Card #_____ EXP date _____ Category_____

3-Full Name _____ D.O.B ____/_____/_____SSN _____-_____-_____RELATIONSHIP_____

US Citizen ○ Green card ○ TPS ○ Card #_____ EXP date _____ Category_____

Company Information

Company's Name: _____ Company's Phone Number (_____) _____-_____

Salary Rate $_____ Hourly ____ Weekly ____ Monthly ___ Yearly ___ # of hours per week _____FT___PT ___ Temporary

Spouse's Employment Information (if she's actively working)

Company's Name: _____ Company's Phone Number (_____) _____-_____

Salary Rate $_____ Hourly ____ Weekly ____ Monthly ___ Yearly ___ # of hours per week _____FT___PT ___ Temporary

Salary Expected for 20 $_____Any Dependent Actively Working? Yes_____ No _____ I don't know

Family Income expected for 20 _____

Dependent's Employment Information

Company's Name: _____ Company's Phone Number (_____) _____-_____

Salary Rate $_____ Hourly ____ Weekly ____ Monthly ___ Yearly ___ # of hours per week _____FT___PT ___ Temporary

Coverage and Billing Information

Plan Selected _____ Plan Cost Premium $_____ Client's Monthly Premium $ _____

Total Subsidy $ _____ **Coverage Start Date _____/_____/_____**

CREDIT CARD | CHECKING ACCOUNT | ADDITIONAL INFO

PAYMENT INFORMATION NOT COLLECTED ON THIS FORM

Do not write card, CVV, routing, or bank account details here.

Full time student: Yes___ No__

Actively in school: Yes___ No __

Have Medicare/ Medicaid

ID# _____

Loan /Alimony $ _____

Does your employer offer health or life coverage? Yes___ No ___

Are you Pregnant? Yes __ No __

AGENT OR AGENCY NAME

_____

PHONE _____

Processing Date:

Coverage Information and documents required:

Client Signature_____