Fax or email completed form to:

Fax: (614) 764-9992 Email: bdjohnsonins@aol.com

Client Information

Requested Effective Date:

Name:

County:

Street Address:

Zip:

City: State:

Phone 1:

Email:

Phone 2:

List all family members who appear on client's ***federal tax return***:

	Name	Birth Date	Gender	Need Coverage? Y/N	Tobacco Use Y/N	Projected Annual $ Income $
Primary						
Spouse						
Child 1						
Child 2						
Child 3						
Child 4						

Best time to call: ________________________ *Anyone eligible for employer coverage, if yes, who:* ____________________________

Current coverage: _______________________ *Current premium:* _______________________ *Renewal date:* ____________________

If not Open Enrollment provide Qualifying Event ____________________________ ***& Qualifying Event date:*** ____________________

Other notes:

Agent : _____________________________ ***Phone:*** ____________________ ***Email:*** ___________________________

HEMA Office Use

Subsidy:	Premium:	App ID:
Net Premium:	Eff Date:	Plan:

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