HEMA | Health Enrollment Management Agency

Fax or email completed form to:
Fax: (614) 764-9992 Email:
info@brucejohnsoninsurance.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:

Revised 4/2015