Medical Insurance Questionnaire

Name: _____ Phone: _____

Home Address: _____ZIP:_____

Mailing Address (if different): _____

Primary Email: _____

Current Insurer: _____ Monthly Premium: $_____

Household members:	Birthday:	Relation to you	Coverage Desired?
1) Self		Self	Yes ☐ No ☐
2)			Yes ☐ No ☐
3)			Yes ☐ No ☐
4)			Yes ☐ No ☐
5)			Yes ☐ No ☐

(For additional Household Members, provide same info on a separate sheet)

If you feel you must only have a plan that includes services provided by your existing Doctor, please indicate the name and phone number of your Doctor:

_____

If you believe your household Modified Adjusted Gross Income (MAGI) is between 100% and 400% of the Federal Poverty Level (FPL), Please indicate your MAGI:

$_____ . If you do not know your MAGI, please refer to your most-recent Tax Return.

Please return this completed questionnaire to Michelle@Maher-Insurance.com or by fax: 310-935-4522. For any questions, please call Michelle Maher Ford : 310-935-4533