PEEK HEALTH.COM

HEALTH SURVEY

Referring Agent/Marketer/Client: _____

Marketplace Permission given on _____ for _____

- Does your employer offer health coverage at work? _____ (Yes/No)

  If yes, is the cost of dependent coverage (if any) affordable to you? _____ (Yes/No)

  If no, who are your friends at work who may need coverage? _____

- Did you complete your taxes for the previous year? _____ (Yes/No)
- Total number of household members including yourself? (# claimed on tax return, including adults): _____
  - Number in household who need ACA coverage? _____
- Do you, your spouse or dependents have a serious health issue that requires treatment? _____ (Yes/No)
- Preferred Plan: _____ $ Preferred budget: _____

PERSONAL INFORMATION – APPLYING? _____ (Y/N)

Full Legal Name: _____

SSN: _____ DOB: _____

Email: _____

Cell #: _____ Home #: _____

Street Address _____

City _____ County _____

State _____ Zip Code _____

Marital Status? _____ (Single/Married)

US Citizen? _____ Gender: _____ (Male/Female)

Tobacco Use? _____ (Yes/No)

If yes, please enter the date of last use: _____

SPOUSE'S INFORMATION – APPLYING? _____ (Y/N)

Full Legal Name: _____

SSN: _____ DOB: _____

Email: _____

Cell #: _____ Home #: _____

US Citizen? _____ Gender: _____ (Male/Female)

Tobacco Use? _____ (Yes/No)

If yes, please enter the date of last use: _____

DEPENDENT INFORMATION *(If Applicable)*

Answer Questions "Yes/No"

1. Full Name: _____

SSN: _____ DOB: _____

US Citizen? ____ Lives at Home? _____ **APPLYING? ____**

2. Full Name: _____

SSN: _____ DOB: _____

US Citizen? ____ Lives at Home? _____ **APPLYING? ____**

3. Full Name: _____

SSN: _____ DOB: _____

US Citizen? ____ Lives at Home? _____ **APPLYING? ____**

4. Full Name: _____

SSN: _____ DOB: _____

US Citizen? ____ Lives at Home? _____ **APPLYING? ____**

Additional Dependents? _____

MLIC Information: Height _____ Weight _____

Mother's Maiden Name _____

Best Time to Call: _____

Client Name: _____

EMPLOYMENT AND FINANCIAL INFORMATION

Will you be claimed by anyone as a dependent for tax purposes? _____ (Yes/No)

If married, will you file your income taxes jointly? _____

Employer Name/Phone: _____

_____

Your Income: $ _____

Spouse's Employer: _____

Spouse's Income: $ _____

Projected Annual Income Next Year? _____

Currently pay or receive alimony? _____ (Yes/No)

Currently receive Disability pay? _____ (Yes/No)

If yes, amount paid per month: $ _____

Or amount received per month: $ _____

Are you a full time student? _____ (Yes/No)

Driver's License # _____

Issue State: _____

BANK/CREDIT CARD INFORMATION

Bank Name: _____

Name on Account: _____

Account Number: _____

Routing Number: _____

OR Credit Card: Card Type _____ (Visa/MC)

Card #: _____

Exp: _____ CVV: _____

Name as it appears on card:

_____

REFERRALS

Name: _____ # _____

Name: _____ # _____

Name: _____ # _____

Name: _____ # _____

Name: _____ # _____

Disclosure and Consent Agreement: If _____ (Agent) /Peek Performance Insurance helps me find a plan that I like and can afford, I am giving my consent for this agent/agency to apply on my behalf for the programs/products that we have discussed. I wish for Peek Performance Insurance / _____ (Agent) to be my Agent(s) of Record for 365 days/the next Calendar year, following my enrollment, for my chosen health plan. I wish for this/these agent(s) to be my Authorized Representative(s) so that he/she may speak to healthcare.gov, insurance carrier or other appropriate representatives on my behalf to provide documentation, ask and answer questions, make payments, etc. By consenting to this agreement, I authorize Peek Performance Licensed Insurance Agent/Agency, _____ (Agent), its affiliates, employees and agents, to use the confidential information on this form that I have provided by phone and/or on this document only for the purposes of determining eligibility for healthcare coverage subsidy, enrollment in healthcare and/or related government assistance or other insurance plans or non-profit health programs, and in making application for healthcare program or coverage and other insurance products. I give my permission for the above mentioned entities/persons to contact me for the purposes of further determining eligibility, educating me on health and other insurance options and/or setting an appointment or means to review and/or sign an application for insurance. I understand that no confidential/private information will be shared with any outside entity other than those described above.

Date: _____ Time: _____ Location: _____

Print Name: _____ Signature: _____

OFFICE USE: Healthcare.gov User Name: _____ Password: _____

ACA Application ID: _____ Company/Plan Name: _____

Monthly Premium: _____ Monthly Subsidy: _____ Annual Deductible: _____ Max OP: _____

Life? ___ Acc? ___ GAP? ___ CI? ___ C/HS? ___ DVH? ___ DI? ___ STM? ___ Faith-Based? ___ Other? _____