Agent: _____ **Referral Type:** _____ **Date:** _____

Primary Policyholder

Name: _____ DOB: _____ SSN: _____ Smoker Status: _____

Address: _____ City: _____State: ____ Zip: _____County: _____

Phone Number: _____ Email Address: _____

Current Insurance Info

Company: _____ Policy Number: _____ Effective Date: _____

Physicians

Name	Par/Non-Par	Provider #	NPI #

Medications

Name	Covered Yes/No	Tier	Requirements/Limits

Spouse/Domestic Partner

Name: _____ DOB: _____ SSN: _____ Smoker Status: _____

Current Insurance Info

Company: _____ Policy Number: _____ Effective Date: _____

Physicians

Name	Par/Non-Par	Provider #	NPI #

Medications

Name	Covered Yes/No	Tier	Requirements/Limits

Dependents

Name: _____ DOB: _____ SSN: _____ Sex: _____

Name: _____ DOB: _____ SSN: _____ Sex: _____

Name: _____ DOB: _____ SSN: _____ Sex: _____

Physicians

Name	Par	Provider #	NPI #

Medications

Name	Covered Yes/No	Tier	Requirements/Limits

Subsidy Information

Primary Policyholder Income: _____
Spouse/Partner Income: + _____
Total Household Income: = _____

Marketplace/ASC

Representative Name: _____
Reference #: _____

I/we certify that all the information provided is accurate to the best of my/our knowledge. If any information changes, I/we understand that the information is to be updated on the Marketplace. I/we understand and have reviewed all the information with my/our agent and have come to the below conclusion .If Applicable, I/we are attesting that all information has been provided to me/us and I/we have elected to sign up for coverage off the market.

_____ _____
Primary Signature Date

_____ _____
Spouse/Domestic Partner Signature Date

_____ _____
Agent Signature Date

Plan of Action:

For Office Use Only

Non-Medicare

IST App ID: _____
OEP: ____ SEP: ____ (If SEP, attach details!)
Marketplace ID: _____Off: _____
Network: _____ Metal: _____
Office Code: _____

Medicare

Access Blue IST: _____
IEP: ____ ICEP: ____ AEP: ____ SEP: ____ (If SEP, attach details!)
HMO: _____ PPO: _____ Supplement: _____
SOA Method: Telephonic: _____ Paper: _____
Office Code: _____