Empower BROKERAGE

Confidential Health Insurance Review
Agent Name:_____
Phone:_____
Email:_____

Date _____ Coverage Type(ACA/ST Medical) _____

Coverage Period _____ Maximum Budget $ _____

PRIMARY APPLICANT INFORMATION

Name _____ DOB _____ Age _____ Male/Female _____ Tobacco _____

Address _____ City _____ State _____ Zip _____ County _____

Home Phone _____ Cell Phone _____ Email _____

Marital Status _____ US Citizen _____ Are you or your family offered employer sponsored health coverage?_____

Reported Household Income $ _____ Reported Household Size _____

Does the primary applicant need coverage? _____ Are any applicants eligible for other coverage? _____

Are any applicants currently pregnant or have a child under 19? _____

Does any applicant have pre-existing health conditions (describe) _____

_____

_____

What type of coverage do you have currently? Carrier _____ Monthly Premium $ _____

WHO IS APPLYING FOR COVERAGE

Name	DOB	Male/Female	Tobacco	US Citizen	Relationship to Primary

CURRENT MEDICATIONS(Pharmacy:_____)

Who takes this Rx	Rx Name	Date Prescribed	Dosage Frequency	Diagnosis	Copay $

CURRENT PHYSICIANS

Provider/Facility Name	Specialty Type	Location	Phone	Accepted Plans

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QUOTES

MAXIMUM COVERAGE $$$	MODERATE COVERAGE $$	MINIMUM COVERAGE $
Medical Plan Name/Premium $	Medical Plan Name/Premium $	Medical Plan Name/Premium $
Supplemental Plan Name/Premium $	Supplemental Plan Name/Premium $	Supplemental Plan Name/Premium $
Dental/Vision Plan Name/Premium $		
Total Premium: $_____	Total Premium: $_____	Total Premium: $_____

COMMENTS