PEEK HEALTH.COM

HEALTH SURVEY

Referring Agent/Marketer: _____

Phone: _____ NPN: _____ FFM: _____

- Do you currently have health insurance? **Y / N**

  No? If we found you something affordable would you like to see it? **Y / N** _____

- Do you work/have income? **Y / N** If yes, do you fall within the FPL levels? **Y / N**
- Does your employer offer coverage at work? **Y / N**

  If yes, is the cost of dependent coverage affordable to you? **Y / N**

  If no, are there others at your job who may need coverage? **Y / N**
- If married, does your spouse have insurance offered where they work? **Y / N**
- Did you complete your taxes for 2016/2017? **Y / N**
- Total number of household members including yourself? (# claimed on tax return, including adults): _____
- Do you, your spouse or dependents have a serious health issue that requires treatment? **Y / N**
- Preferred Plan: _____ $ Preferred budget: _____
- Are you, your spouse or dependents on Medicaid or Medicare? **Y / N** _____

PERSONAL INFORMATION – APPLYING? Y / N

Full Legal Name: _____

SSN: _____ DOB: _____

Email: _____

Cell #: _____ Home #: _____

Street Address _____

City _____ County _____

State _____ Zip Code _____

US Citizen? **Y / N** Gender: **M / F** **Single / Married**

Tobacco Use? **Y / N**

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? **Y / N** Gender: **M / F** Tobacco Use? **Y / N**

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

DEPENDENT INFORMATION *(If Applicable)*

1. Full Name: _____

SSN: _____ DOB: _____

US Citizen? **Y / N** Lives at Home? **Y / N** **APPLYING? Y / N**

2. Full Name: _____

SSN: _____ DOB: _____

US Citizen? **Y / N** Lives at Home? **Y / N** **APPLYING? Y / N**

3. Full Name: _____

SSN: _____ DOB: _____

US Citizen? **Y / N** Lives at Home? **Y / N** **APPLYING? Y / N**

4. Full Name: _____

SSN: _____ DOB: _____

US Citizen? **Y / N** Lives at Home? **Y / N** **APPLYING? Y / N**

Additional Dependents? _____

MLIC Information: Height _____ Weight _____

Mother's Maiden Name _____

Best Time to Call: _____

Referring Agent/Marketer: _____ Client Name: _____

EMPLOYMENT AND FINANCIAL INFORMATION

Will you be claimed by anyone as a dependent for tax purposes? **Y / N** _____

If married, will you file your income taxes jointly? **Y / N**

Employer Name: _____

Your Income: $ _____

Spouse's Employer: _____

Spouse's Income: $ _____

Projected 2019 Annual Income? _____

Currently pay or receive alimony? **Y / N** Disability **Y / N**

If yes, amount paid per month: $ _____

Or amount received per month: $ _____

Are you a full time student? **Y / N**

Driver's License # _____

Issue State: _____

BANK/CREDIT CARD INFORMATION

Bank Name: _____

Name on Account: _____

Account Number: _____

Routing Number: _____

OR VISA / MC (circle one) Exp: _____ CVV: _____

Card #: _____

Name as it appears on card:

_____

REFERRALS

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/Calendar year of 2019 for my chosen health plan, and 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, _____ , 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: _____

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? _____