AFFORDABLE CARE ACT (OBAMACARE) INTAKE FORM

DO YOU CURRENTLY HAVE MEDICAL COVERAGE OR DO YOU QUALIFY FOR OTHER MEDICAL COVERAGE FOR 2019? Yes or No

APPLICANT INFORMATION

First Name:	Last Name:	
Date of birth:	SSN:	Phone:
Current Address:		Apt/Bldg #:
City:	State: Florida	ZIP Code:
Email:	Citizen: Yes or No	Naturalized or Born in U.S.A.
Naturalization Certificate or Resident Green Card (Circle if applicable)	Did you recently gain eligible immigration status? Yes or No	
USCIS#: NOB:	Married: Yes or No	

FAMILY & HOUSEHOLD

(INCLUDE ALL INDIVIDUALS THAT WILL BE SHOWN ON YOUR 2019 INCOME TAX RETURN)

NAME	DOB	SOCIAL SECURITY NUMBER	RELATIONSHIP	INCOME	APPLYING FOR COVERAGE (YES OR NO)

INCOME

Current Employer:		
Employer Address:		Phone:
City:	State:	Zip Code:
Position:	Annual Income:	Do you expect to make the same amount of income in 2019? Yes or No

SPOUSE INFORMATION

First Name:	Last Name:	
Date of birth:	SSN:	Phone:

SPOUSE EMPLOYMENT INFORMATION

Current Employer:		
Employer Address:		Phone:
City:	State:	Zip Code:
Position:	Annual Income:	Do you expect to make the same amount of income in 2019? Yes or No

ADDITIONAL QUESTIONS

Will file a 2019 tax return? Yes or No	Any individuals above with disabilities/mental health issues that affect their capability to work? Yes or No
Claiming dependents for 2019? Yes or No	Any individuals above pregnant? Yes or No
Are you of Hispanic, Latin or Spanish origin (optional)? Yes or No	Anyone above recently adopted or placed in foster care? Yes or No
American Indian or Alaska Native? Yes or No	Did you recently move? Yes or No
Did anyone above recently get married? Yes or No	Will anyone shown above lose coverage within 60 days? Yes or No
Any individuals above recently released from incarceration? Yes or No	Any individuals found not eligible for Medicaid or CHIP since 11/01/18? Yes or No
Any individuals above need help with activities of daily living? Yes or No	Does anyone above pay alimony or student loans? Yes or No

Privacy Notice Statement: I hereby agree that the information contained herein has been provided to the best of my knowledge. I understand that the information provided herein will be solely used by Healthcare Advisors LLC (DBA: GotToBeInsured.com) to determine eligibility through Healthcare.gov/ACA and will not be disseminated to any third party without your prior consent.

Signature of applicant:	Date:
Signature of spouse *(only if joint)*:	Date:

******* Upon completion please email (apply@gottobeinsured.com) / Fax: 800-873-5906 / Drop at office *******

INTERNAL USE ONLY: APP ID: _____ PTC: _____ INSURER: _____ EFF DATE: _____