



ACA Pre-screening Application

Application ID#: _____

Date: _____ MRN #: _____ FACS # _____ PII Notice Read: Yes No
Last Name: _____ First Name: _____ DOB: ____/____/____
Social Security: _____ Address: _____ Apt/Lot: _____
City: _____ State: _____ Zip: _____ County: _____
Land Line: (____) _____ - _____ Cell: (____) _____ - _____ Permission to Contact by email: cell phone:
Email Address: _____

U.S. Citizen?	Yes	No	American Indian/Alaskan Native?	Yes	No
Are you pregnant?	Yes	No	How many babies are expected in this pregnancy:		
Are you a smoker?	Yes	No	Does your Employer offer insurance/COBRA?	Yes	No

Number of People claimed on Taxes: _____ Tax Filing Status: _____ Joint? _____

INCOME Source: – BEFORE TAXES OR DEDUCTIONS: Total Household Income: \$ _____ / _____

Employer: _____ Phone: (____) _____ - _____ Full/Part Time? _____ Income \$ _____

Self – Additional income: Source: _____ \$ _____ /month X _____ = \$ _____ /year

Spouse/Partner: _____ DOB: _____ SSN: _____ Smoker?

Employer: _____ Phone: (____) _____ - _____ Full/Part Time? _____ Income \$ _____

Spouse/Partner: – Additional income: Source: _____ \$ _____ /month X _____ = \$ _____ /year

Does your Employer offer insurance/COBRA? Yes No

Dependents Claimed on Taxes:

Name: _____ DOB: _____ SSN: _____ Smoker?

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Location: CHE CHN CHB UTMC

I consent to allow The WellFund to enroll me in the ACA for plan year _____.

I would like to get more information about the ACA from a licensed agent before enrolling in the ACA.

SIGNATURE: _____ DATE: _____