

# Health Insurance Application Form

## Applicant Information

Name:		
Date of Birth:		
Gender:	<input type="checkbox"/> Male	<input type="checkbox"/> Female <input type="checkbox"/> Other
Phone Number:		
Email:		
Address:		
City:	State:	Zip:
Postal Code:	Country:	

## Identification Information

ID Number (Passport / National ID):
Social Security / National Insurance Number (if applicable):

## Employment Information

Employment Status:
Employer Name:
Employer Address:
Job Title:
Work Phone Number:

## Insurance Coverage Details

Type of Coverage Requested:
Preferred Coverage Start Date:
/ /
Primary Care Physician (Optional):

## Medical Information

Do you currently have health insurance?  
 Yes  No

Do you have any existing medical conditions?  
 Yes  No

If yes, please describe:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Emergency Contact

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

## Applicant Declaration

I confirm that the information provided in this application is true and accurate.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_