Health Insurance Application Form

Applicant Information

Name:
Date of Birth:
Gender: ☐ Male   ☐ Female   ☐ Other
Phone Number:
Email:
Address:
City: State: Zip:

Employment Information

Employer Name:
Occupation:
Employer Phone:

Coverage Information

Type of Coverage Requested:

☐ Individual

☐ Family

Preferred Start Date: _____

Primary Physician (if any):

_____

_____

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: _____