



<b>Agent:</b>		<b>Date:</b>			
<b>Client Information Form</b>					
<b>Full Name (Primary):</b>					
<b>Marital Status:</b>		Single <input type="checkbox"/> Married <input type="checkbox"/>			
<b>Spouses Name:</b>					
<b>Phone#:</b>		ALT:			
<b>Address:</b>					
<b>City:</b>					
<b>State:</b>		Zip:			
<b>Email*</b>					
<b>Birth date:</b>					
<b># of people needing coverage:</b>					
<b>Primary Social Security #:</b>					
<b>Dependants:</b>	<b>Name:</b>	<b>Birth date</b>	<b>SS#</b>	<b>Sex</b>	<b>Needs Coverage</b>
				M / F	<input type="checkbox"/>
				M / F	<input type="checkbox"/>
				M / F	<input type="checkbox"/>
				M / F	<input type="checkbox"/>
<b>Employer :</b>				<b>Phone#:</b>	
<b>Household Income:</b>		\$			
<b>Primary Care Physician(s)</b>	<b>Name:</b>			<b>Specialty:</b>	
<b>Physical Ailments requiring treatment</b>					
<b>Prescriptions</b>	<b>Name:</b>			<b>Dosage:</b>	



Agent Use Only Below			
<b>Client Name</b>			
<b>Plan:</b>			
<b>Subsidy :</b>			
<b>Premium:</b>			
<b>Application ID:</b>			
<b>Notes:</b>			
<b>EFT</b>	Bank:		
	Account#:	Routing#:	
<b>Payment</b>	Visa, MC, Disc	CC#	Exp / CCV

This form is used for the sole purpose as reference information for providing customer service with health and supplemental insurance products. It will not be used for any other reason in compliance the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I hereby authorize the above agent and ACA Benefits LLC or agent of, to oversee all aspects of my enrollment and coverage in the healthcare marketplace or heathcare.gov. By signing this document I give full authority to the above agent to sign on my behalf for the only purpose of enrolling me in healthcare:

Sign: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Agent : \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_



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