ACA
Insurance Group

Agent:	Date:

Client Information Form

Full Name (Primary):					
Marital Status:	Single ☐ Married ☐				
Spouses Name:					
Phone#:		**ALT:**			
Address:					
City:					
State:		**Zip:**			
Email*					
Birth date:					
# of people needing coverage:					
Primary Social Security #:					
Dependants:	**Name:**	**Birth date**	**SS#**	**Sex**	**Needs Coverage**
				M / F	☐
				M / F	☐
				M / F	☐
				M / F	☐
Employer :		**Phone#:**			
Household Income:	$				

Primary Care Physician(s)	**Name:**	**Specialty:**
Physical Ailments requiring treatment		
Prescriptions	**Name:**	**Dosage:**

ACA
Insurance Group

Agent Use Only Below				
Client Name				
Plan:				
Subsidy :				
Premium:				
Application ID:				
Notes:				
EFT	Bank:			
	Account#:	Routing#:		
Payment	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:_____

ACA Benefits LLC

10 Strecker Ave, Suite 1090
Ellisville, Mo 63011
Office: (314) 779-4722
Email: Info@acainsuresme.com
www.ACAinsuresme.com