Section A: Applicant(s)

Applicant Name: _____

SSN#: _____

PRIMARY APPLICANT

☐ NEW COVERAGE ☐ ADD DEPENDENT ☐ CHANGE IN COVERAGE

FIRST NAME, MIDDLE INITIAL, LAST NAME	SOCIAL SECURITY NUMBER	SEX M F	DATE OF BIRTH

DO YOU HAVE A PREFERRED SPOKEN LANGUAGE BESIDES ENGLISH? Y N
IF YES, PLEASE SPECIFY:

DO YOU HAVE A PREFERRED WRITTEN LANGUAGE BESIDES ENGLISH? Y N
IF YES, PLEASE SPECIFY:

***WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO?** 4 OR MORE TIMES PER WEEK ON AVERAGE, EXCLUDING RELIGIOUS OR CEREMONIAL USES Y N
IF YES, PLEASE PROVIDE DATE OF LAST USE:

IF HISPANIC/LATINO, ETHNICITY (OPTIONAL—CHECK ALL THAT APPLY)
☐ MEXICAN ☐ MEXICAN AMERICAN ☐ CHICANO/A ☐ PUERTO RICAN
☐ CUBAN ☐ OTHER_____

RACE (OPTIONAL—CHECK ALL THAT APPLY) ☐ WHITE ☐ BLACK OR AFRICAN AMERICAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN INDIAN ☐ CHINESE ☐ FILIPINO
☐ JAPANESE ☐ KOREAN ☐ VIETNAMESE ☐ OTHER ASIAN ☐ NATIVE HAWAIIAN ☐ GUAMANIAN OR CHAMORRO ☐ SAMOAN ☐ OTHER PACIFIC ISLANDER ☐ OTHER_____

RESIDENTIAL ADDRESS - STREET, CITY, STATE, ZIP	COUNTY

MAILING ADDRESS - STREET, CITY, STATE, ZIP (IF DIFFERENT THAN ABOVE)

PRIMARY PHONE CELL ☐ LANDLINE ☐	SECONDARY PHONE CELL ☐ LANDLINE ☐
EMAIL ADDRESS	**PREFERRED CONTACT METHOD** ☐ EMAIL ☐ POSTAL MAIL
PRIMARY CARE PHYSICIAN (REQUIRED)	**PCP#** (REQUIRED)

DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (REQUIRED) Y N
IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:

SPOUSE AND/OR DEPENDENT CHILDREN TO BE COVERED (dependent children must be under age 26)†

FIRST NAME, MIDDLE INITIAL, LAST NAME	RELATIONSHIP	SOCIAL SECURITY NUMBER	SEX M F	DATE OF BIRTH

DO YOU HAVE A PREFERRED SPOKEN LANGUAGE BESIDES ENGLISH? Y N
IF YES, PLEASE SPECIFY:

***WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO?**
4 OR MORE TIMES PER WEEK ON AVERAGE EXCLUDING RELIGIOUS OR CEREMONIAL USES Y N
IF YES, PLEASE PROVIDE DATE OF LAST USE:

IF HISPANIC/LATINO, ETHNICITY (OPTIONAL—CHECK ALL THAT APPLY)
☐ MEXICAN ☐ MEXICAN AMERICAN ☐ CHICANO/A
☐ PUERTO RICAN ☐ CUBAN ☐ OTHER_____

RACE (OPTIONAL—CHECK ALL THAT APPLY) ☐ WHITE ☐ BLACK OR AFRICAN AMERICAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN INDIAN ☐ CHINESE ☐ FILIPINO
☐ JAPANESE ☐ KOREAN ☐ VIETNAMESE ☐ OTHER ASIAN ☐ NATIVE HAWAIIAN ☐ GUAMANIAN OR CHAMORRO ☐ SAMOAN ☐ OTHER PACIFIC ISLANDER ☐ OTHER_____

*MAILING ADDRESS - STREET, CITY, STATE, ZIP (IF DIFFERENT THAN ABOVE)	COUNTY

PRIMARY PHONE CELL ☐ LANDLINE ☐	EMAIL ADDRESS	PREFERRED CONTACT METHOD ☐ EMAIL ☐ POSTAL MAIL

PRIMARY CARE PHYSICIAN (REQUIRED)	PCP# (REQUIRED)

DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (REQUIRED) Y N
IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:

FIRST NAME, MIDDLE INITIAL, LAST NAME	RELATIONSHIP	SOCIAL SECURITY NUMBER	SEX M F	DATE OF BIRTH

DO YOU HAVE A PREFERRED SPOKEN LANGUAGE BESIDES ENGLISH? Y N
IF YES, PLEASE SPECIFY:

***WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO?**
4 OR MORE TIMES PER WEEK ON AVERAGE EXCLUDING RELIGIOUS OR CEREMONIAL USES Y N
IF YES, PLEASE PROVIDE DATE OF LAST USE:

IF HISPANIC/LATINO, ETHNICITY (OPTIONAL—CHECK ALL THAT APPLY)
☐ MEXICAN ☐ MEXICAN AMERICAN ☐ CHICANO/A
☐ PUERTO RICAN ☐ CUBAN ☐ OTHER_____

RACE (OPTIONAL—CHECK ALL THAT APPLY) ☐ WHITE ☐ BLACK OR AFRICAN AMERICAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN INDIAN ☐ CHINESE ☐ FILIPINO
☐ JAPANESE ☐ KOREAN ☐ VIETNAMESE ☐ OTHER ASIAN ☐ NATIVE HAWAIIAN ☐ GUAMANIAN OR CHAMORRO ☐ SAMOAN ☐ OTHER PACIFIC ISLANDER ☐ OTHER_____

*MAILING ADDRESS - STREET, CITY, STATE, ZIP (IF DIFFERENT THAN ABOVE)	COUNTY

PRIMARY PHONE CELL ☐ LANDLINE ☐	EMAIL ADDRESS	PREFERRED CONTACT METHOD ☐ EMAIL ☐ POSTAL MAIL

PRIMARY CARE PHYSICIAN (REQUIRED)	PCP# (REQUIRED)

DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (REQUIRED) Y N
IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:

* Age 18 and over.
† The designation of spouse shall include domestic partners.