Individual/Family Plan Request Form

E. Mann Insurance Services
** Return completed form via email, fax or mail: **
310 W. Laskey Rd. Toledo, OH 43612
kberger@emanninsurance.com
Office: 419.724.3647 | Fax: 1.419.754.2021

1 **I am interested in discussing my options regarding:**

Coverage:	**Current or Prior Coverage:** ☐Group ☐Individual		
☐ Medical	Medical	_____	Monthly Premium: $ _____
☐ Dental	Dental	_____	Monthly Premium: $ _____
☐ Vision	Vision	_____	Monthly Premium: $ _____

*Referred by: _____

2 **Please complete the information below. Social Security numbers are *not* required.**

Name:_____

(Primary Residence) Street: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: _____Cell☐ Home☐ E-Mail: _____

Date of Birth: _____ Tobacco Use? ☐ Yes ☐ No (if Yes, who?):

Social Security No.: _____ Estimated Annual Household Income for 2023: _____
(This amount is used to determine eligibility for premium tax credit.)

3 **Dependent/Family Info (if to be covered)**

Name: _____
Dependent Type: _____
Date of Birth: _____
Social Security No: _____

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Name: _____
Dependent Type: _____
Date of Birth: _____
Social Security No: _____

If you are requesting information regarding health insurance plans and have specific Doctors, Hospitals and/or Brand name prescriptions, please list them below.

- ❑ _____ _____
- ❑ _____ _____
- ❑ _____ _____
- ❑ _____ _____
- ❑ _____ _____
- ❑ _____ _____

Individual Consent Form

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I, _____ , give my permission to Kelly Berger (NPN: 19195188) to serve as the health insurance agent or broker for myself and my entire household if applicable, for purposes of enrollment in a Qualified Health Plan offered on the Federally Facilitated Marketplace. By consenting to this agreement, I authorize the above-mentioned Agent to view and use the confidential information provided by me in writing, electronically, or by telephone only for the purposes of one or more of the following:

1. Searching for an existing Marketplace application;
2. Completing an application for eligibility and enrollment in a Marketplace Qualified Health Plan or other government insurance affordability programs, such as Medicaid and CHIP or advance tax credits to help pay for Marketplace premiums;
3. Providing ongoing account maintenance and enrollment assistance, as necessary; or
4. Responding to inquiries from the Marketplace regarding my Marketplace application.

I understand that the Agent will not use or share my personally identifiable information (PII) for any purposes other than those listed above. The Agent will ensure that my PII is kept private and safe when collecting, storing, and using my PII for the stated purposes above.

I confirm that the information I provide for entry on my Marketplace eligibility and enrollment application will be true to the best of my knowledge. I understand that I do not have to share additional personal information about myself or my health with my Agent beyond what is required on the application for eligibility and enrollment purposes. I understand that my consent remains in effect until I revoke it, and I may revoke or modify my consent at any time in writing via email or mail.

Name of Applicant: _____

Signature: _____

Date: _____

This Contract Expires: ☐ 12 mo or ___/___/___ (specified date)

(If date is not selected, contract will expire 1 year from signature date.)