Disclosure Agreement: *By signing this document, I authorize Peek Performance Licensed Insurance Agent/Agency, _____, its affiliates, employees and agents, to use the confidential information on this document only for the purposes of determining eligibility for healthcare coverage subsidy, enrollment in healthcare and/or related government assistance or other insurance programs, and in making application for healthcare coverage and other insurance products. No application for ANY product will be submitted on my behalf until I have chosen it and have given consent to purchase. I give my permission for the above mentioned entities/persons to contact me for the purposes of further determining eligibility, educating me on health and other insurance options and/or setting an appointment or means to review and/or sign an application for insurance.*

Print Name	Signature	Date

Referrals:

Name: _____ Phone: _____
Name: _____ Phone: _____
Name: _____ Phone: _____

OFFICE USE

Email Address: _____

Healthcare.gov User Name: _____

Password: _____

Application ID: _____

Company/Plan Name: _____

Monthly Premium: $_____

Monthly Subsidy: $_____

Annual Deductible: $_____

Annual Max Out of Pocket: $_____

Life?___ Acc?___ GAP?___ CI?___ C/HS?___ Dental?___ DI?___

Referring Agent Name: _____

PEEK PERFORMANCE INSURANCE

Do You Qualify for Affordable Health Insurance?

Open Enrollment Dates
Nov. 1st – Dec. 15th

_____
Agent Name

_____
Phone

_____ _____
(FFM ID) (NPN)

I wish for _____(Agent) to be my Agent of Record for my chosen health plan, and I wish for this agent to be my Authorized Representative so that he/she may speak to healthcare.gov or other appropriate representative on my behalf to provide documentation, ask and answer questions, etc.

Signed _____ Date _____

Printed Name: _____

Contact Number: _____

Email: _____

SEP or **OEP** (circle one)

If SEP, reason for qualification: _____

Please Seal Upon Completion

Personal Information

Full Legal Name | Date of Birth

SSN | US Citizen? **Y / N**

Cell # | Tobacco Use? **Y / N**

Home # | **Single / Married**

Email | Gender: **M / F**

Spouse's Information (if applicable)**:**

Spouse's Full Legal Name | Date of Birth

SSN | US Citizen? **Y / N**

Cell # | Tobacco Use? **Y / N**

Home # | Gender: **M / F**

Street Address (Residence/Mailing)

City | **County** | **State** | **Zip**

	Dependent 1	Dependent 2	Dependent 3
Last Name			
First Name			
SSN			
Date of Birth			
Age			
US Citizen?	Yes / No	Yes / No	Yes / No
Lives at Home	Yes / No	Yes / No	Yes / No
Ever been in Foster Care?	Yes / No	Yes / No	Yes / No

Please answer all questions below:

Are you, your spouse or dependents on Medicaid or Medicare? **Y / N**

If you/your spouse answered yes to tobacco use, please enter the date of last tobacco use: Self _____ Spouse _____

Will you be claimed by anyone as a dependent for tax purposes? **Y / N**

If married, will you file your income taxes jointly? **Y / N**

Employer Name_____ Your Income $_____

Spouse's Employer _____ Spouse's Income $_____

Does your spouse have insurance offered where they work? **Y / N**

Projected 2018 Annual Income? $ _____

Do you currently pay or receive alimony? **Y / N**
If yes, Amount Paid per month: $ _____
OR Amount Received per month: $ _____
Are you a full time student? **Y / N** Interest on a student loan? **Y / N**
If yes, how much? $ _____

Bank / Credit Card Information

Bank Name: _____

Name on Account: _____

Account Number: _____

Routing Number: _____
OR
Visa / MC (circle one) Card # _____

Exp: _____ Name as it appears on card: _____

CUL Information

Height _____ Weight _____ Mother's Maiden Name _____

Referring Agent Name: _____