

Zylinsky Insurance Agency Client Information Form (ACA)

Date _____ Person Completing Form _____ Appt Made: _____

Primary Insured _____ Birthdate _____

Full name

Home Phone _____ Cell _____ Smoker ☐ Y ☐ N

Please circle preferred number. Also share whose cell number you provide.

Household Income _____ If married, do you file jointly: ☐ Y ☐ N # of dependents claimed: _____

Required for ACA Application: INCLUDE all sources of income for all family members to determine possible subsidy for healthcare insurance premium.

Address _____

County _____ E-Mail _____

Primary Care Doctor _____ Dentist _____

Optometrist _____ Other Specialist _____

Preferred Hospital _____ Preferred Pharmacy _____

Please list all prescription medications for those to be insured on the reverse.

Have you had insurance coverage in the last 60 days? ☐ Y ☐ N

Current Insurance/Employer: _____ End Date: _____

(if NONE please put end date of last)

If you have Medicaid please include Member ID otherwise put NA _____

Medicare: ☐ Supplement ☐ Advantage ☐ Part D Eligible Dates: Part A ____/____/____ Part B ____/____/____
(prescription)

Information you want us to know _____

Spouse Name _____ Spouse Birthdate _____

(if including for coverage; write NA if not applicable) Please complete PAGE 3 for additional dependents.

Primary Care Doctor _____ Dentist _____

Optometrist _____ Other Specialist _____

Preferred Hospital _____ Smoker ☐ Y ☐ N

Have you had insurance coverage in the last 60 days? ☐ Y ☐ N

Current Insurance/Employer: _____ End Date: _____

(if NONE please put end date of last)

If you have Medicaid please include Member ID otherwise put NA _____

Medicare: ☐ Supplement ☐ Advantage ☐ Part D Eligible Dates: Part A ____/____/____ Part B ____/____/____
(prescription)

Spouse information you want us to know _____

Please list all prescription medications (not over the counter) for Primary Insured. Be sure to include aerosols/inhalers, creams/ointments, insulin, durable medical equipment (CPAP/oxygen), and other injectables.

Insured Name:		Preferred Pharmacy:		
Name of Medicine(s) Do you use generic when available? YES OR NO (circle one, please)		Dosage	Number of Doses Taken Each Day	Amount Received Each Month

**If more room is needed, please add an additional sheet and be sure to include the individual's name.*

Please list all prescription medications (not over the counter) for Spouse/Dependent to be insured. Be sure to include aerosols/inhalers, creams/ointments, insulin, durable medical equipment (CPAP/oxygen), and other injectables.

Spouse Name:		Preferred Pharmacy:		
Name of Medicine(s) Do you use generic when available? YES OR NO (circle one, please)		Dosage	Number of Doses Taken Each Day	Amount Received Each Month

Additional Dependents to be Insured (if applicable)

Date _____ Person Completing Form _____ Appt Made: _____

Primary Insured _____ Birthdate _____

Spouse Name _____ Spouse Birthdate _____

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Dependent Name _____ Birthdate _____

Primary Care Doctor _____ Pharmacy _____

Dentist _____ Optometrist _____

Please list all prescription medications for this person being insured. Be sure to include aerosols/inhalers, creams/ointments, insulin, durable medical equipment (CPAP/oxygen), and other injectables.

Dependent Name: _____				
Name of Medicine(s) Do you use generic when available?	YES OR NO (circle one, please)	Dosage	Number of Doses Taken Each Day	Amount Received Each Month

Dependent Name _____ Birthdate _____

Primary Care Doctor _____ Pharmacy _____

Dentist _____ Optometrist _____

Please list all prescription medications for this person being insured. Be sure to include aerosols/inhalers, creams/ointments, insulin, durable medical equipment (CPAP/oxygen), and other injectables.

Dependent Name: _____				
Name of Medicine(s) Do you use generic when available?	YES OR NO (circle one, please)	Dosage	Number of Doses Taken Each Day	Amount Received Each Month

Feel free to duplicate this form as needed for additional dependents.