

INDIVIDUAL INSURANCE FORM

Please Fax back to: Elite Insurance Associates @ 904-527-1318

Preferred Agent (Optional): _____

PLEASE QUOTE -- Check all that applies: HEALTH DENTAL/VISION LIFE OTHER: _____

PRIMARY APPLICANTS GENERAL INFORMATION

Is anyone eligible for Group Insurance? _____ Do you currently have insurance or COBRA: _____

First Name: _____ MI: _____ Last Name: _____

Social Security #: _____ Age: _____ DOB: _____ Gender: _____

Home Address: _____ City: _____ County: _____ State: _____ Zip: _____

Phone Numbers: Best: _____ Secondary: _____

E-mail Address: _____ Tobacco Usage (yes or no): _____

Annual Income: \$ _____ Spouses' Annual Income: \$ _____

Married? YES NO Filing Jointly? YES NO Total number of people in household: _____

If you are married and applying for a Tax Subsidy, you must file a joint Income Tax Return.

Name of Employer: _____ Phone # of Employer: _____

Spouses' Employer: _____ Phone # of Spouses' Employer: _____

List all dependents:

Last Name:	First Name:	MI:	SSN:	Gender:	DOB:	Relationship:	Tobacco Usage?	Are we applying for Coverage?

Signature: _____ **Date:** _____

Please Note: The information contained in this form should match your IRS tax filing and is required in order to determine eligibility. Your signature authorizes communications that may be in the form of email, text or calls when necessary to obtain additional information while processing your application.



Elite Insurance Associates

INDIVIDUAL INSURANCE FORM

Please Fax back to: Elite Insurance Associates @ 904-527-1318

Preferred Agent (Optional): _____

If you are interested in determining if your current Physicians, Hospitals and Medications are covered, please list them below:

Primary Care Physician: _____

Pediatric Physician: _____

Specialist: _____

Specialist: _____

Specialist: _____

Preferred Hospital: _____

Medications Name: _____ Dose: _____ How Often Taken: _____

Medications Name: _____ Dose: _____ How Often Taken: _____

Medications Name: _____ Dose: _____ How Often Taken: _____

Medications Name: _____ Dose: _____ How Often Taken: _____

Medications Name: _____ Dose: _____ How Often Taken: _____

Medications Name: _____ Dose: _____ How Often Taken: _____



Elite Insurance Associates

1710 Shadowood Lane, Unit 240 Jacksonville, Florida 32207 904-527-1304

www.eiafl.com