ACA Enrollment Form

About You:

Name: _____ SSN: _____ Birthdate: _____

Gender: M ____ F ____ Marital Status: _____ Do you have existing coverage? Yes ____ No ____

Address: _____ City: _____ State: _____

Zip Code: _____ County: _____ Phone Number: _____

Email Address: _____ Do you use tobacco? Yes____ No____

About Your Employment & Income:

Employer Name: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Phone Number: _____

Wages/Tips (before taxes): _____ Hourly____ Weekly____ Bi-Weekly____ Monthly____

Yearly____ Average hours worked per week: _____

About Your Spouse:

Name: _____ SSN: _____ Birthdate: _____

Gender: M ____ F ____

Does your spouse have existing coverage? Yes ____ No ____ Do you use tobacco? Yes____ No____

About Your Spouse's Employment & Income:

Employer Name: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Phone Number: _____

Wages/Tips (before taxes): _____ Hourly ____ Weekly ____ Bi-Weekly ____ Monthly ____

Yearly ____ Average hours worked per week: _____

Other Income: Check all that apply. If checked, give amount and how often you receive it.

Unemployment ____ Alimony ____ Pension ____ Social Security ____ Disability ____ Retirement ____

Other Income ____ How often do you receive this income? _____What Type? _____

About Your Dependent Children:

Child 1: _____ SSN: _____ Birthdate: _____

Gender: M ____ F ____ Existing coverage? Yes ____ No ____ Do you use tobacco? Yes____ No____

Child 2: _____ SSN: _____ Birthdate: _____

Gender: M ____ F ____ Existing coverage? Yes ____ No ____ Do you use tobacco? Yes____ No____

About Your Children's Income:

Employer Name: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Phone Number: _____

Wages/Tips (before taxes): _____ Hourly ____ Weekly ____ Bi-Weekly ____ Monthly ____

Yearly ____ Average hours worked per week: _____

Residency Information:

Is everyone in the household a United States citizen? Yes ____ No ____ If no, complete the following:

Name: _____ Alien Number: A-_____ Card Number _____

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I certify that all statements are complete and true and I understand that any additional information such as proof of income, residency, etc., requested by the Health Insurance Marketplace is my responsibility. Subsidies that are quoted are calculated and determined by the Healthcare Marketplace.

Signature of Applicant: _____ Date: _____