HORAN
Health. Wealth. *Life.*

# Individual Health Insurance Quote Request

## Personal Information

1. Company Name: _____ Name: _____

Phone: _____ Date of birth: _____Preferred Pharmacy: _____

Address: _____ Zip code: _____

Tobacco Use: Y or N (Circle one) Email: _____ County: _____

2. Name: _____ Date of Birth: _____ Tobacco Use: Y or N _____
3. Name:_____ Date of Birth: _____ Tobacco Use: Y or N _____
4. Name:_____ Date of Birth: _____ Tobacco Use: Y or N _____
5. Name:_____ Date of Birth: _____ Tobacco Use: Y or N _____

**Number of Individuals on Tax Return:** _____ **Estimated 2020 Annual Household Income:** $_____
(Both used to determine premium subsidy eligibility)

## Option 1- ACA Health Insurance □

*(Please check all that apply)*

**Plan Type**: □ Traditional Copay □ Health Savings Account (HSA) □ High Deductible Health Plan (HDHP)

Preferred Hospital: _____

Preferred Doctors: _____ _____

_____ _____

**Additional Benefits**: □ Dental □ Vision

## Option 2- Short Term Insurance

**Plan Type**: □ Traditional Copay □ High Deductible Health Plan (HDHP)

**Additional Benefits**: □ Prescription Coverage □ Dental □ Vision

** **HORAN** offers assistance with Medicare Supplements, Medicare Advantage and Medicare Part D plans in Ohio, Kentucky, Indiana, Colorado, Virginia and Florida. (Different form required)**

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