

**Steinlage Insurance Agency Appointment Intake**

**If you are applying for Medicare please complete page 1 and 3. If you are applying for ACA (under 65) please complete page 2 and 3.**

Full Legal Name: Spouses Name and DOB (if applicable):

Date of Birth:

Medicare #

Part A/B Dates:

**(if applicable)**

Best Contact Number:

Email:

Physical Address:

Mailing Address **(If different from above)**:

Employer Name:

Current Work/Retirement Situation:

Current coverage carrier name:

Premium cost (Please let us know how much you pay and how much your partner pays if applicable):

Deductible, Max Out of Pocket:

Are you currently drawing social security:

Adjusted Household Gross Income **(Last Three Years)**:

**For ACA please complete page 2 and 3.**

Full Legal Name and Date of Birth **(Please list all individuals needing coverage, Spouse and Children if applicable)**

Social Security #’s **(Individuals Needing Coverage/Including the SS number for those on the tax return even if they aren’t getting insurance)**

Best Contact Numbers **(Individual and Spouse)**

Physical Address:

Mailing Address (if different from above)

Name of Employer:

Current Work Situation:

Current coverage Name/Type, Premium (Please let us know how much you pay and how much your partner pays if applicable), Deductible, Max Out of Pocket:

Is current coverage HSA Compatible/Are you funding this:

Current Coverage End Date:

Have you ever claimed unemployment?

Modified Adjusted Gross Income Amount for the last three years

**\*Income is counted for you, your spouse, and everyone you'll claim as a tax dependent on your federal tax return. \***

**Current Prescriptions:** **(Do NOT include over the counter (OTC) meds)**

**\*\*Attach List if Needed\*\***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  **Medication Name** | **Dosage (mg, mL)** | **Modifier (XL, XR, CL)** | **# Per day** | **Qty per month** | **Tablet/Capsule/Ointment/Cream** | **Mail Order/Retail** |
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**Current Providers**

|  |  |  |  |
| --- | --- | --- | --- |
| **Doctor Name** | **Specialty (Primary, Cardiologist, Pulmonologist)** | **Office Phone Number** | **Office Location** |
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Preferred Pharmacy:

Specific Questions/Topics to Discuss:

How did you hear about us?

Our agents at Steinlage Insurance Agency strive to provide a personalized experience for our clients. This information is requested to help research the best options for our clients. Our agents review this information prior to the appointment to prepare in helping our clients navigate their insurance needs!

We look forward to meeting with you!

Thank you!

Steinlage Insurance Team