Borshoff & ASSOCIATES
Accountable Business Solutions for Your Future's Benefit

Individual Quote Sheet

Family Information

Subsidy: Cost Sharing:

Please answer all questions. Please print legibly.

☐ Single ☐ Married ☐ Divorced Number of Dependents _____

								(Y or N)
Applicant:		Gender:		DOB:		SSN:		Smoker:
Spouse:		Gender:		DOB:		SSN:		Smoker:
Child 1:		Gender:		DOB:		SSN:		Smoker:
Child 2:		Gender:		DOB:		SSN:		Smoker:
Child 3:		Gender:		DOB:		SSN:		Smoker:
Child 4:		Gender:		DOB:		SSN:		Smoker:

Address: _____ Phone: _____

_____ Cell: _____

City: _____ State: _____ Zip _____ Fax: _____

County: _____ Email: _____

Income Information (Please put all income as annual income)

Salary

Applicant Income: _____ Spouse Income: _____ Total Income: _____

Business Income

Gross Income: _____ Business Expenses: _____ Total Income: _____

Other Income

Social Security: _____ Pension/Retirement: _____

Investment: _____ Dependent Income: _____

Total Other Income: _____

Total Estimated AGI: _____

Number of people on your taxes: _____

See Income Calculation Supplement

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Work Information

Applicant's Employer Information

Applicant Employer: _____

Employer Address: _____

Employer Phone: _____ Employer Contact Name: _____

Is group coverage available? _____ **Are spouse's eligible for coverage?** _____ **Cost:** _____

Deductible: _____ **Coinsurance:** _____ **Out of Pocket:** _____

Dr. Copay: **Rx Copays:**

Spouse's Employer Information

Spouse's Employer: _____

Employer Address: _____

Employer Phone: _____ Employer Contact Name: _____

Is group coverage available through spouse's employer? _____ **Are spouse's eligible for coverage?** _____ **Cost:** _____

Deductible: _____ **Coinsurance:** _____ **Out of Pocket:** _____

Dr. Copay: **Rx Copays:**

Doctor and Medication Information

Hospital Preference:	
Pharmacy Preference:	

Doctor's Full Name	Address (At least Zip Code)

Full Medication Name	Generic?	Dosage	How Often	Retail or Mail? How Often?	Person

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Full Medication Name	Generic or Brand Name?	Dosage	How Often	Retail or Mail? How often?	Person
Notes:					

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Health Insurance Options

PLEASE INDICATE YOUR PREFERENCES

Carriers ☐ Ambetter ☐ Anthem ☐ Assurant ☐ Humana ☐ PHP ☐ UHC
☐ On Exchange ☐ Off Exchange

Metal Level ☐ Catastrophic ☐ Bronze ☐ Silver ☐ Gold ☐ Platinum

Coverage
☐ Individual ☐ Individual + Spouse
☐ Individual + Children ☐ Family

Plan Type
☐ HSA ☐ PPO ☐ HMO

Deductible
☐ $500 ☐ $1000 ☐ $2000
☐ $2500 ☐ $3500 ☐ $5000
☐ $7500 ☐ $10,000 ☐ _____

Coinsurance
☐ 50% ☐ 70% ☐ 80%
☐ 90% ☐ 100%

Dental: ☐ Dr. Office Copay: ☐ Prescription Copays: ☐
Vision: ☐ 1st Dollar: ☐

Current Health Insurance

Company: _____ **Deductible:** _____

Coinsurance: **Premium:** _____ **Prescription**

☐ HSA ☐ PPO ☐ HMO Copay: ___/___/___
☐ 50% ☐ 70% ☐ 80% Mail: ___/___/___
☐ 90% ☐ 100% Dental: ☐ Vision: ☐
Dr. Office Copay: _____ 1st Dollar: ☐

Life Insurance Options

Face Amount: _____

☐ Term Life Insurance ☐ Universal Life
☐ 10 years ☐ 15 years ☐ 20 years ☐ 30 years ☐ Whole Life

Waiver of Premium
☐ Yes ☐ No

Approximate Monthly Budget Amount :

Reason for Coverage:

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