Health Directions™
Health Insurance Planning

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INDIVIDUAL HEALTH INSURANCE FORM

PART A - CLIENT INFORMATION

PLEASE COMPLETE THE FOLLOWING PERSONAL INFORMATION			DATE ENTERED:
Name (First / Middle / Last)	☐ Male ☐ Female	Date of Birth	Marital Status ☐ Single ☐ Married ☐ Family ☐ Divorced ☐ Widow(er)
Address (Number & Street)		City / State / Zip Code	
Phone Numbers Day: Eve: Cell:			Email Address
Current Insurance	Date		Referred By

PART B - APPLICANT, SPOUSE and DEPENDENT INFORMATION

COMPLETE FOR YOU AND YOUR SPOUSE (IF APPLYING FOR COVERAGE)					
	FIRST NAME	MI	LAST NAME	DATE OF BIRTH	ZIP CODE
APPLICANT					
SPOUSE					
DEPENDENT					
DEPENDENT					
DEPENDENT					
DEPENDENT					

PART C - PHYSICIAN AND HEALTH PROVIDER INFORMATION

LIST THE NAME OF EACH DOCTOR, TYPE, AND TOWN FOR ALL FAMILY MEMBERS									
			FOR OFFICE USE ONLY						
DOCTOR'S NAME	SPECIALTY	TOWN	AETNA	ANTHEM	CT CARE	CIGNA	MEDI SHARE	UNION	UNITED HEALTH CARE
Dr. John Doe	*Internal Medicine*	*Fairfield*							

PART D - PRESCRIPTIONS & MEDICATIONS

LIST CURRENT MEDICATIONS, DOSE, AND FREQUENCY FOR ALL FAMILY MEMBERS									
			FOR OFFICE USE ONLY						
PRESCRIPTION NAME	DOSE	FREQUENCY (Per Day)	AETNA	ANTHEM	CT CARE	CIGNA	MEDI SHARE	UNION	UNITED HEALTH CARE
Lipitor	10mg	1							

NOTES:

SIGNATURE: _____ **DATE:** _____

REP SIGNATURE: _____ **DATE:** _____