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Health Insurance With Care – Simplified

BENEFITS AND PERCS 2026 HEALTH INSURANCE QUESTIONNAIRE

Today's Date: _____ Full Name: _____ Referred by: _____

Address: _____ City _____ Zip: _____ Is this a new address? Y ☐ N ☐

County: _____ Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email Address: _____ Desired Monthly Premium: $_____

Self-Employed or 1099 worker? Y ☐ N ☐ If **YES**, please specify occupation: _____

List ALL Individuals to be covered by Insurance (yourself, spouse, dependents, etc.) Please start with your name first:	**Date of Birth:**	**Current Age:**	**Smoker:**	**Does this person take Medication?**
_____	_____	_____	Y ☐ N ☐	Y ☐ N ☐
_____	_____	_____	Y ☐ N ☐	Y ☐ N ☐
_____	_____	_____	Y ☐ N ☐	Y ☐ N ☐
_____	_____	_____	Y ☐ N ☐	Y ☐ N ☐
_____	_____	_____	Y ☐ N ☐	Y ☐ N ☐

To see if you qualify for a government subsidized plan, please provide us with your best estimate of your net 2026 projected income. Include all household income if you file a joint tax return. The subsidy is based on your **net taxable income**. This means it's the amount you'll be taxed on, after subtracting any household deductions. $_____

Tell us about your Current Plan- use Membership Card, Carrier Plan Summary, or create a copy PDF from a COMPUTER SCANNER

Insurance Company Name: _____ **Policy End Date:** _____
What type of health plan do you have? (please check below) (Important for meeting carrier deadline for next policy)

Individual ☐ Connect for Health * ☐ Employer ☐ COBRA ☐ Health First (Medicaid) ☐
*Is your Connect for Health a subsidized plan (Y ☐ N ☐)

Copays- Office: $_____ Specialty $_____ Deductible: $_____ Coinsurance: %_____ Out of Pocket Max: $_____
Current monthly premium $_____ What is the highest deductible you would consider for your next plan $_____

Do you have the resources to cover a high-deductible plan? Y ☐ N ☐

Do you have any ongoing medical conditions that require medical care? Y ☐ N ☐

Do you want to keep your current doctor(s) and / medications for your medical needs? Y ☐ N ☐

Please continue to Page 2 and Complete

Please fill out the following with your doctor's information

Then, to secure your first "BPQ Review" appointment, you will need to find which insurance carrier(s) your doctor(s) are contracted with. **Please go to our website** *www.benefitsandpercs.com* and click on "Search for a Doctor" where you can find our helpful "Doctor Search Tip Sheets" to find your doctors. ***Skip the doctor search if you are only seeking a Kaiser health plan.***

Doctor's Name (First & Last)	Group Practice Name (Required)	Specialty (ex: Dermatologist)	Zip Code	Click all the carrier(s) your Dr(s) are contracted with. AE=Anthem PWY Essentials • AP=Anthem PWY • C=Cigna R=Rocky Mountain HP • S=Select Health
				AE☐ AP☐ C☐ R☐ S☐
				AE☐ AP☐ C☐ R☐ S☐
				AE☐ AP☐ C☐ R☐ S☐
				AE☐ AP☐ C☐ R☐ S☐
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				AE☐ AP☐ C☐ R☐ S☐
				AE☐ AP☐ C☐ R☐ S☐

If you or any family members take daily or monthly prescriptions, LIST ALL information below:

Name of Medication	Dosage (mg/ml)	Frequency (Ex. 3x/day)	List the Family Member Name(s) taking this Medication

Once completed send your BPQ to administration@benefitsandpercs.com

Are there any health insurance carriers that you prefer not to use or have had a difficult experience with? Y ☐ N ☐
If **YES,** which carriers? _____ **Would you like a quote on dental coverage?** Y ☐ N ☐

What is the most important criteria when seeking a health plan? (Rate in Priority 1-5; **1 is your top priority**)

Premium _____ Doctor(s) _____ Hospital _____ Level of Benefits _____ Rx (Pharmacy) _____

Are there additional benefits you would like to consider? (Check all that apply): International Travel / Trip Insurance ☐
Accident ☐ Cancer ☐ Heart / Stroke ☐ Critical Illness ☐ Vision ☐ Life Insurance ☐
Would you like a quote on: Auto ☐ Home ☐ **Would you like help buying or selling a home?** Yes ☐ No ☐

Full Name: _____ **Today's Date** _____

Other comments: _____

Thank you for your interest and I look forward to connecting with you soon! ~ Melanie ~