Melanie S. Kantor
CO License Number 2042

Office: 303-758-1442

www.benefitsandpercs.com

Health Insurance With Care - Simplified

BENEFITS AND PERCS 2024 HEALTH INSURANCE QUESTIONNAIRE

Today's Date: Full Name: Referred by:

Address: City Zip:

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?
		Age	Y N	Y N
		Age	Y N	Y N
		Age	Y N	Y N
		Age	Y N	Y N
		Age	Y N	Y N
		Age	Y N	Y N

To see if you qualify for a government subsidized plan, please provide us with your best estimate of your net **2024* 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 is the figure that you will be taxed on and has been reduced by any deductions your household is entitled. $

Tell us about your Current Plan- use your Membership Card, Plan Summary Document, or scan a copy from your computer scanner.

Insurance Company Name: **Policy End Date:**
(Important for meeting carrier deadline for next policy)

What type of health plan do you have? (please check below)

Individual Employer COBRA Connect for Health Health First (Medicaid)

-Is your Connect for Health a subsidized plan? (Y/N)

OV: $ SP: $ Deductible: $ Coinsurance %: OOPM: $

(Office visit co-pay) (Specialist office co-pay) (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 condition(s) that require medical care? Y N

Do you want to keep your current doctor(s) and/or 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, in order to secure your first appointment "BPQ Review" you will need to find which insurance carrier(s) your doctor is contracted with. Please go to our website *www.benefitsandpercs.com* and click on "Search for a Doctor" where you can find and download our helpful "Carrier Tip Sheets" to find your doctors. Once completed send your BPQ to administration@benefitsandpercs.com

Doctor's Name (First & Last):	Group Practice Name (Required):	Specialty (ex. OBGYN):	Zip Code:	Click all the carrier(s) your dr is 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 ☐
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				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:

Are there any health insurance carriers that you prefer **not** to use or had a difficult experience with? Y ◯ N ◯

If **YES** which carriers?

Would you like a quote on dental coverage? Y ◯ N ◯

Have you ever been on a Medicaid/ Health First plan in the past? Y ◯ N ◯

If **YES**, when did it terminate?

If **YES**, which state(s)?

What is the most important criteria when seeking a health plan? (Rate in priority order 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)

☐ Dental ☐ Accident ☐ Critical Illness

☐ Cancer ☐ Heart/Stroke ☐ Life Insurance ☐ Vision

Would you like a quote on? ☐ Auto ☐ Home

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

Other comments:

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