

# 2018 Health Insurance Fact Find

- Please provide your family data to apply for health insurance and **Obamacare-SHOP**.



Home address \_\_\_\_\_  
 Home phone # \_\_\_\_\_ Company Name \_\_\_\_\_  
 Email address \_\_\_\_\_

**Health Insurance Providers List:**

- Providence
- Kaiser
- Blue Cross
- Lifewise
- Oregon HP, etc.

Legal Name All family members listed on tax form 1040 (First Mid Last)	Birthday (m-d-yy)	Relation	Gender (M / F)	Social Security Number	Driver License #, state	US-Citizen/ Greencard # /or Others	Anyone Smoking? (Yes / No)
		Self					

**Sample Data Entry**

Evelyn Y. Smith	6/15/69	Wife	F	321-45-6789	1234567, OR	US Citizen	No
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**Employment:** Date hired (mm/yy) \_\_\_\_\_, Average work hours/week \_\_\_\_\_, Business owner? ( Yes, No ).

**Family Income:** If you apply for financial ads for health insurance, we need your family income data. Please fill your family income Last Month (2017) total \$ \_\_\_\_\_, and projected year 2018 total \$ \_\_\_\_\_. For verification, we need copy of last month payroll pay-stubs, 2016 W-2 and tax return Form1040 (first two pages).

(Note, if your **other family members** are not going to apply for Obamacare health insurance, you can **skip** their family income.)

**Tips:** Use your cell phone to take pictures of documents and email the pictures to us: [hwu475@gmail.com](mailto:hwu475@gmail.com).

**Agreement:** I am \_\_\_\_\_ (print name). I agree to provide my family personal data (birthday, SSN, income, etc.) for Henry Hu Agency to assist me to apply for benefits of health insurance. I know the data will be forwarded to US government and I agree to take full responsibility for the data I provided. Henry Hu Agency will keep the data confidential for applying insurance only and protect privacy of all applicants.

Applicant signature \_\_\_\_\_

Date \_\_\_\_\_

**Henry Hu** Farmers Insurance and FFM Agent  
 - 16 years serving Oregon and Washington  
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# Employer / Owner Insurance Fact Find

( Note, this form is for owner/managers to complete )

Business/Company Name
Business Address (local)
Mailing address for billing
Federal employer tax ID (FEIN)
Office telephone #
Business description (what type)

## Company contact person / manager

Name
Title
Phone #
email

## Company health insurance information

Total employees (on payroll) #
Company contribution (to pay 50%, or 100%)
Employees how to qualify (fulltime, hours/week)
Insurance for family members (yes, no)?

## Company workers compensation insurance

Insurance company name
Policy number
Current policy expire date

## This form prepared by

Name	_____
Title	_____
Date	_____

