Individual Health Quote Request Form

HORAN
Health. Wealth. *Life.*

Personal Information

Company Name: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Phone: _____ Date of Birth: _____ Preferred Pharmacy: _____

Address: _____ Zip Code: _____

Tobacco Use: ☐ Yes ☐ No Email: _____ U.S. County: _____

Spouse and/or Dependents to be covered:

1. Name: _____ Date of Birth: _____ Tobacco Use: ☐ Yes ☐ No
2. Name: _____ Date of Birth: _____ Tobacco Use: ☐ Yes ☐ No
3. Name: _____ Date of Birth: _____ Tobacco Use: ☐ Yes ☐ No
4. Name: _____ Date of Birth: _____ Tobacco Use: ☐ Yes ☐ No

Number of Individuals on Tax Return: _____ Estimated 2023 Annual Household Income: _____

Both used to determine premium subsidy eligibility

☐ **Option 1: ACA Health Insurance –** *Please check all that apply.*

Plan Type: ☐ Traditional Copay ☐ Health Savings Account (HSA) ☐ High Deductible Health Plan (HDHP)

Preferred Hospital(s): _____

Preferred Doctor(s): _____

Additional Benefits: ☐ Dental ☐ Vision

☐ **Option 2: Short-Term Insurance –** *Please check all that apply.*

Plan Type: ☐ Traditional Copay ☐ High Deductible Health Plan (HDHP)

Additional Benefits: ☐ Prescription Coverage ☐ Dental ☐ Vision

HORAN also offers assistance with Medicare Supplements, Medicare Advantage and Medicare Part D plans in Ohio, Kentucky, Indiana, Colorado, Virginia and Florida. A separate form is required.

Please select your advisor: I_do_not_have_an_advisor

Advisor Email Address: IHM@horanassoc.com

Click to Email Form to Advisor