



Health Exchange
Marketplace Agency



Section A: Applicant Summary Information

Realtor Name:

Address:

City, State, Zip

E-mail:

Phone:

Effective Date:

Section B: Person(s) To Be Insured

Family Member	NAME (Last Name, First Name)	BIRTH DATE	Annual Income	Primary Physician	TOBACCO USE
Primary (realtor)					Y N
Spouse					Y N
Child 1					Y N
Child 2					Y N
Child 3					Y N
Child 4					Y N
Child 5					Y N

Other Information

BOR Affiliation

Current Coverage, or
"NONE" (if HSA, need detail)

Coverage Effective Date

Total Household Income

Preferred Contact (e-mail
or phone; time of day)

PLEASE FAX OR EMAIL TO THE SCHELLER BRADFORD GROUP

Fax (513) 528-6058 or E-mail: john.harder@schellerbradford.com or

heather.hopper@schellerbradford.com

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