Insurance Input form

	US Citizen	Smoker	American Indian Alaskan Native	On Medicaid?	Include on policy?	Life Insurance	Need Dental?

Insured Information

Name ______________________

DOB __________ SSN __________ File joint return? Y/N

Income ______________________

Employer & Phone ______________________

Spouse ______________________

DOB __________ SSN __________

Income ______________________

Employer & Phone ______________________

Other Dependents

Name ______________________

DOB __________ SSN __________ Relationship: Son/daughter/__________________

Name ______________________

DOB __________ SSN __________ Relationship: Son/daughter/__________________

Name ______________________

DOB __________ SSN __________ Relationship: Son/daughter/__________________

Name ______________________

DOB __________ SSN __________ Relationship: Son/daughter/__________________

Name ______________________

DOB __________ SSN __________ Relationship: Son/daughter/__________________

Plan Chosen/% of discount/Total Adjusted Gross Income ______________________

Street Address ______________________ Mailing Address? Y / N

City/State/Zip ______________________

County ______________________

Phone __________ Cell __________

email ______________________

* By signing below, I acknowledge that all information given is accurate and that I am not currently incarcerated. I understand that Cornerstone Wealth Advisory Group or my agent cannot be held liable for difference in premium inaccuracies on this form.
(Initial here to confirm that you have read the previous statement) _________

Applicant Signature ______________________ Date __________

Doctor / Clinic / Rx

Notes: