

# Health Care is Changing



PDCM Insurance can help you determine if you are on the BEST health care plan available and if you are eligible to receive a subsidy. You have the right to know what options are available to you for health care.

**We will never charge you for professional agent guidance.**

To better assist you with determining your health care options, we ask that you fill out the following form.

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## Personal Information

<b>First Name</b>	<b>MI</b>	<b>Last Name</b>
<b>Gender</b>	<b>Date of Birth</b>	<input type="text"/>
<b>Age</b>		
<b>Tobacco Use</b>	Yes	No

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<b>Home Address</b>		
<b>Address (Line 2)</b>		
<b>City</b>		
<b>State</b>	<b>ZIP Code</b>	
<b>Phone</b>	<b>E-mail</b>	
<b>Preferred Method of Contact</b>	Phone	E-mail

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**Do you qualify for a subsidy?** If you would like to find out, please complete the information below.

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<b>Annual Household Income*</b>		<b>How many people live in your household?</b>
<b>Do you or your spouse have access to group health insurance?</b>	Yes	Group
	No	Individual

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**Annual Household Income is ONLY required to determine if you can qualify for a subsidy.**

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## Spouse Information

First Name

MI

Last Name

Date of Birth

Tobacco Use

Yes

No

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## First Dependent Information

First Name

MI

Last Name

Date of Birth

Tobacco Use

Yes

No

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## Second Dependent Information

First Name

MI

Last Name

Date of Birth

Tobacco Use

Yes

No

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## Third Dependent Information

First Name

MI

Last Name

Date of Birth

Tobacco Use

Yes

No

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**CONFIDENTIAL:** You can feel safe with your information in our hands. We use a secure network, and treat all information as personal and confidential.

We appreciate you taking the time to complete the form. Our licensed staff will promptly enter your information. If you have any questions regarding this process, you are always welcome to call our office at **(319) 234-8888**.

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I certify that all statements are true to the best of my knowledge and belief and I understand that a copy of this form will be made available to me at my request. I authorize PDCM Insurance to submit my information onto the Marketplace to retrieve competitive quotes in my honor and to determine if I am eligible for a subsidy.

Signature \_\_\_\_\_

Date \_\_\_\_\_