2020 Enrollment Form for ACA Coverage

Please return to Covered Bridge Insurance. Your application will be date stamped and processed in the order received. Due to the constraints of Open Enrollment deadlines, we encourage you to complete and return this form ASAP! Please use Legal Names and include ALL information.

You may complete this – it is fillable -then save and return to info@coveredbridgeinsurance.com OR Fax to: 262-376-9005 OR mail: W67N222 Evergreen Blvd, Ste N116, Cedarburg, WI 53012

Name: _____ Date of birth: _____ Age:_____ Gender: Select

TOB/Vaping: Select Or Applying for Coverage? Select One: Social Security Number: _____

Medications:_____

CONTACT INFO: Street: _____ City:_____

State: _____ Zip: _____ COUNTY:_____Cell phone: _____

e-mail: _____ Home phone: _____

Preferred Network/Provider Groups:_____

Complete for all family members who will be claimed on your tax return in 2020:

Spouse name: _____ Date of birth: _____ Age:_____ Gender: Select

TOB/Vaping: Y N Applying for Coverage? Y N Social Security Number: _____

Medications:_____

Child 1 name: _____ Date of birth: _____ Age:_____ Gender: Select

TOB/Vaping: Y N Applying for Coverage? Y N Social Security Number: _____

Medications:_____

Child 2 name: _____ Date of birth: _____ Age:_____ Gender: Select

TOB/Vaping: Y N Applying for Coverage? Y N Social Security Number: _____

Medications:_____

Child 3 name: _____ Date of birth: _____ Age:_____ Gender: Select

TOB/Vaping: Y N Applying for Coverage? Y N Social Security Number: _____

Medications:_____

Do you expect to be eligible for a subsidy? Y N
If yes, please compete the following income information for all family members.

Please NOTE: Income is based on the calendar year from Jan 1 – Dec 31, 2020. It is reported on your 2020 tax return and your tax credit (subsidy) is reconciled with the IRS at that time (usually April 2021). You MUST reconcile your tax credit by April 15th to keep any subsidy you are receiving.

Income of each family member (including dependents) is included in my household income number.

Income for: _____ Source of Income: _____ Annual Income: _____
(name of person) (Job, Pension, Social Security…)
Employer name (if any): _____ Employer Phone Number (if any) _____

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Total Expected Income in 2020: _____

DEDUCTIONS: Please indicate the $ amount of any planned contributions to Traditional IRA's and/or HSA accounts.

IRA Contribution _____ HSA Contribution: _____

I understand:

1. Any tax credit received and taken will be reconciled on my income tax return and may potentially be charged back to me on my taxes if I exceed the income qualifications.
2. I must file a joint tax return if I am married.
3. Any changes in income or family structure (ie not claiming a dependent as planned or getting married or divorced, etc.) will affect my tax credit (subsidy) and must be reported/changed on my application asap.

My signature below authorizes Covered Bridge Insurance to complete my enrollment for 2020 health insurance coverage using the information I have provided above.

I will review my application after the enrollment is complete and verify the correct plan has been selected.

Name: _____ Date:_____