*SoarLife Insurance Services, LLC*

*Helping you and yours SoarLife with affordable health care. . .*

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For your free personal assistance with enrolling in Covered California or Medi-Cal, complete form and send, including copy of CA Driver Lic., to: fax 951.588.8555, e-mail info@soarlife.net, or call 510.326.4026

**Primary Contact**

**1.** First Name | Middle Name (Optional) | Last Name

**2.** Street Address | Street Address 2 (Apt. No.) | Phone | E-mail

**3.** City: | State | Zip | County

**4.** Social Security, ITIN, or Visa # **and** permanent resident or Naturalization number, if applicable. (Please send copy) | DOB | Age | M/F | Pregnant

**5.** Spouse/Partner First Name | Last Name | Social Security, ITIN, or Visa # **and** Lawful or Naturalization number, if applicable | DOB | Age | M/F | Pregnant

**6.** Dependent First Name | Last Name | Social Security, ITIN, or Vias # **and** Lawful or Naturalization number, if applicable | DOB | Age | M/F | Pregnant

**a)** | | a) a)

**b)** | | b) b)

**c)** | | c) c)

**d)** | | d) d)

**Employment Information**

**7.** Employer Name | Gross Annual Income **(Net-income if self employed)** | Medical Benefits Offered Y/N | Cost of Benefits for Employee Only

**8.** Employer Name (Spouse/Partner) | Gross Annual Income **(Net-income if self employed)** | Medical Benefits Offered Y/N | Cost of Benefits for Employee Only

**Other Income**

**9.** Source | Annual Income

**Tax Information**

Filed 2013 Y/N | Filed 2014 Y/N | Filed Joint | Filed Head of House | Filed Single

**Health Information**

**10.** Dr. Visits Per Year (and family member name) | Number of Medications | **12.** Dr. Visits Per Year (Family Member) | Number of Medications

**11.** Dr. Visits Per Year (and family member name) | Number of Medications | **13.** Sign (typing name serve as an e-signature) | Date