MCHA
Mississippi Communities Health Advisers
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CONFIDENTIAL

HEALTH INSURANCE INFORMATION FORM

Please complete the Information below for all Family Members who will be covered under your Health Plan Choice. The purpose of this information is to allow you to consider Ambetter Marketplace Health Insurance. This information will determine if you qualify for the Premium Tax Credit and Cost Sharing savings offered by the Ambetter Marketplace Health Insurance Plans. ***(Please type or print clearly. Return completed forms by email to: sbethel@mscommunitieshealth.com.)***

Household Information

Employer Name	Zip Code	County	Employee Social Security Number	Employee Phone Number

Family Information (Complete for the employee and each dependent)

Name	Filing Status	Date of Birth	Sex	Estimated Income	Smoker
Include the name of the employee and each family member who will or may be included in coverage	Choose one: – Primary – Spouse – Dependent	Month/Day/Year	Male Female	Estimated for 2024 for each person listed	Check box if a smoker
					☐
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Do you or any member of your family have other sources of health insurance? If so, please provide list the other insurer.	Other health insurance:

Estimated Income: Include the estimated gross income for 2024 for each individual who is to be insured. We will provide estimates for single coverage (employee only) and family coverage (employee and dependents) if you prefer.

Household Income: It is important that you include the estimated Taxable Income for **all** Family Members that will be covered under the plan. Total Household Income and the number of Family Members will determine your percentage of the Federal Poverty Level. This percentage will determine if you qualify for tax credits and/or cost sharing and at what levels. If you **under**estimate Taxable Income, you may owe taxes when you file.

Smoker: Please indicate each family member who is a smoker by checking the box. Leave blank if not a smoker.

I acknowledge and agree that I am providing the above information for the sole purpose of obtaining information about the terms of health insurance from Ambetter from Magnolia. All information is kept confidential and is only shared with Ambetter from Magnolia for the sole purpose of providing health insurance.

_____ _____

Employee **Date**