Soby Insurance

ENROLLMENT APPLICATION

MEMBER INFORMATION:

6700 Blvd. suite 1, Charlotte NC 28217
ofc. 980- 859-1234/ Cell 704 345 4008
Fax. 704 266 6365
Sobyinsuranceplans.@gmail.com or shnotary@gmail.com

Last name First initial Social security No

Home Address Street City State Province Zip code

email address (_____)_____ Day time Phone number (_____)_____ Evening Phone number (_____)_____ Day Fax number

Date of birth ___/___/___ Sex: { } Male { } Female Marital Status: { } Married { } Single { } Divorced { } Widowed.
MM DD YYYY

Are you presently insured: { } Yes { } No If, yes details:

I **AM INTERESTED IN:**

(Check all that apply) { } Health { } Dental { } Vision {] Critical illness { } LIFE [ ] FINAL EXPENSE

DEPENDENT INFORMATION: If dependent coverage is requested, list eligible dependents i.e lawful spouse and unmarried dependent children under age 21 or 25 a full time student) attach separate sheet to provide additional dependent information.

Spouses Full Name (Last, First, Mi)	SOCIAL SECURITY	DATE OF BIRTH [ ] MALE [ ] FEMALE
Child name:	Social security No.	Date of birth: [ ] Male [ ] Female
Child name:	Social Security No.	Date of birth: [ ] Male [ ]Female
Child name:	Social Security No.	Date of birth [ ] Male [ ] Female
Child name:	Social security No.	Date of birth [ ] Male [ ] Female
HOUSEHOLD INCOME		
Employer	Employer Phone Number	Gross income: (before taxes) [ ] Week [ ]Bi weekly [ ] Yearly
Spouses employer/Job	Employer Phone Number	Gross income: (before taxes) [ ] Week [ ]Bi weekly [ ] Yearly
Any other income such as retirement or disability? Type: _____ Amount $ _____ How often: _____		
RESIDENCY INFORMATION: Additional information can be submitted on back of from.		
Name:	Alien Number: A:	Card Number:
Name:	Alien Number: A:	Card Number:

Under the law Monetary penalties may apply if you d o not have health coverage, its is important that you keep yourself and your protected! If you do not want to enroll in the health care coverage or any other type of coverage with the help of Soby Insurance (for example your already have coverage though a spouse or independently) please check this box and sing below.

I certify that all statement are complete and true and I understand that additional information such as proof of income residence etc.. requested by the health Insurance Marketplace is my responsibility. Subsidies that are quoted are calculated and determined by the healthcare Marketplace.

Signature of Primary Applicant: _____ Date: _____