WOODARD INSURANCE AGENCY

LEADERS IN AFFORDABLE HEALTH COVERAGE

WELCOME

We are here to help! Woodard is one of the most trusted insurance agencies on the East Coast. Our team of over 50 brokers are licensed, certified and among the most experienced in the business.

Let us guide you through the process…

it's as easy as 1-2-3 !

LET'S GET STARTED

1. We will need a little information. Complete the attached forms and send to us - OR – attend an enrollment session for a face - to - face consultation. (Fax instructions on next page)
2. Let's talk. We want to hear about any questions or concerns you may have regarding your needs and your current doctors
3. Select and secure the perfect plan. We will help you select a plan that best fits your needs giving you peace of mind.

PLANS AVAILABLE FOR: HEALTH / DENTAL, VISION / LIFE & CRITICAL ILLNESS

Still have questions? Call us, we are here to help! **855-856-1600**

ENROLLMENT APPLICATION

WOODARD INSURANCE AGENCY, LLC

Name as it appears on Social Security Card	Phone - -	E mail Address		
Street	City	State	Zip	County

I AM INTERESTED IN: (check all that apply) ☐ HEALTH ☐ DENTAL ☐ VISION ☐ CRITICAL ILLNESS ☐ LIFE

List ALL individuals with in your household that will be included on your 2015 taxes even if they get health coverage elsewhere.
INCLUDE SOCIAL SECURITY NUMBERS FOR ALL DEPENDENTS THAT NEED COVERAGE

	Sex	SSN#	Date of Birth	Primary Doctor
Are you applying for coverage for yourself? Y N	M F	- -	/ /	
Spouse Applying for coverage? Y N	M F	- -	/ /	
Child Is child on Medicaid? Y N	M F	- -	/ /	
Child Is child on Medicaid? Y N	M F	- -	/ /	
Child Is child on Medicaid? Y N	M F	- -	/ /	

Please tell us the name of the hospital you prefer or is closest to your home : ____

IS ANYONE A SMOKER OR HAS SMOKED IN THE LAST 6 MONTHS Y N IF SO WHO? : ____

HOUSEHOLD INCOME

Employer	Employer Phone Number	Gross income (before taxes)	☐ Weekly ☐ Bi-Weekly ☐ Yearly
Spouse Employer/Job 2	Employer Phone Number	Gross income (before taxes)	☐ Weekly ☐ 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 form

Name	Alien Number: A-	Card Number
Name	Alien Number: A-	Card Number

Under the law, monetary penalties may apply if you do not have health coverage. It is important that you keep yourself and your health protected! If you do not want to enroll in health care coverage or any other type of coverage with the help of Woodard Insurance Agency (for example- because you already have coverage through a spouse or independently), please check this box and sign below .

☐ DECLINE COVERAGE

I certify that all statements are complete and true and I understand that any additional information such as proof of income, residency 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: _____________

QUICK ENROLL: FAX COMPLETED Forms to: 888-623-3137

An Enrollment Expert will contact you directly

You can also attend an ENROLLMENT SESSION for a one-on-one consultation.

PRIVACY NOTICE

This notice explains how *Woodard Insurance Agency, LLC* and its *Affiliated Brokers* may collect, use, and share your information. Please read it carefully and contact Rick Woodard, *Woodard Insurance Agency, LLC at 910-622-1364,* if you have any questions.

Why did you give me this notice?	I am/We are legally required to give you this notice by applicable law and our agreement with the federal government. I/We respect your personal information and want you to fully understand how I/we may use and share your information.
What information will you ask me to give you?	I/We must collect certain information about you, called **Personally Identifiable Information** ("PII") in order to help you complete your application for health insurance. PII is information that can be used to identify or trace your identity. These are a few examples of PII: (This is not a complete list) Date of birth, telephone number, name, address, social security number, household income, marital status, race or ethnicity, credit or debit card numbers
How will you use my information?	I/We will use only the information that we need to help you obtain health insurance through the Federally Facilitated Exchange ("FFE") and to provide Authorized Functions approved by the FFE, or other services permitted under applicable law. These are a few of the authorized functions that we may conduct. This is not a complete list: -Helping with your application for insurance -Answering questions about your eligibility -Helping to enroll you in a qualified health plan -Helping with filing Appeals of eligibility determinations -Correcting of errors
Will you share my information with anyone?	I/We may only share your information as described in this notice. I/We may share your information with certain Federal and/or State agencies, the health issuer that you select, or subcontractors that help me/us provide services to you.
What happens if I don't share my information with you?	If you do not want to share your information, you may not be able to enroll in a health insurance plan.
Will you keep my information safe?	YES. I am/We are required to keep your information safe. I/We have developed privacy and security policies that I/we must follow to ensure that we protect your PII.
OPT IN	**I agree to receive text message payment reminders sent to the cell phone number on application. You do have the ability to Opt out at any time.**

I/We must get your permission to share your information for any other purpose that is not already described in this notice.

Applicant Signature ________________________________ Date ______________

Broker / Agent Signature ________________________________ Date ______________