



**MAIN STREET INSURANCE**  
Insurance • Medicare • Retirement

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## Health Insurance Enrollment Form

### Client Information

Name: \_\_\_\_\_

(As it appears on your social security card)

DOB: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Tobacco/Non-Tobacco: \_\_\_\_\_

Marital status: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

County: \_\_\_\_\_

E-mail: \_\_\_\_\_

#### Employer

Primary Insured: \_\_\_\_\_

Spouse: \_\_\_\_\_

#### Total Projected Household Income for 2019 (Gross) :

Primary Insureds portion of household income: \_\_\_\_\_

Spouses portion of household income: \_\_\_\_\_

### Dependents

Applying for insurance: yes / no

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Tobacco / NT

Social Security #: \_\_\_\_\_

### Dependents

Applying for insurance: yes / no

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Social Security #: \_\_\_\_\_

# Additional Dependents:

## Dependents

Apply for insurance: yes / no

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Social Security #: \_\_\_\_\_

## Dependents

Apply for insurance: yes / no

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Social Security #: \_\_\_\_\_

## Dependents

Apply for insurance: yes / no

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Social Security #: \_\_\_\_\_

## Dependents

Apply for insurance: yes / no

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Social Security #: \_\_\_\_\_