Above All Consulting, Inc.

(916) 686- 1070

Pre Enrollment Health Insurance Form- Covered California

Your destination for affordable health care

Medi-Cal

Section I: APPLICANT INFORMATION – Tell us about yourself

Last Name: _____ **First Name:** _____ **Middle Initial**_____ **Nationality/Race:** _____

Social Security Number: _____ - ____ - _____ **Date of Birth (MM/DD/YY)** ___ / ___ / ___ **Gender**: ❒ Male ❒ Female **Primary Language:** _____

Email: _____ **Work Phone**: (____) _____ - _____ **Home Phone**: (____) _____ - _____ Cell Phone: (____) _____ - _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Domestic Partner **Type of Coverage Requested**: ❒ Individual ❒ Family ❒ Other_____

Section II. Tell us about the people who need health coverage. Include information about yourself if you want health coverage.

Last Name	First Name and Middle Initial	Relationship to the Applicant	Social Security Number	Date of Birth	Gender M/F	Hispanic or Latino?	Nationality/Race	U.S. Citizen?	Has Earnings or other Income

Section III. Employment Income – Complete the following for anyone who receives earned income. Include your earnings if you are a spouse or parent of a child listed.

Name of Employed Person	Full-time or part-time student? If yes, name of school	Is this self-employed income?	Employer Name, Address and Phone Number	Hours Worked per Week	Weekly, Monthly or Annual Gross Pay	Date Started

I certify that I have read this form or have had it read to me in a language that I understand & the information given on this form is true & complete to the best of my knowledge.

Applicant Signature: _____ Date: _____ / Organization/Individual Referral: _____