Generic Company

Product Name
Individual Enrollment Form

Payment Transaction ID: XXXXXXXXXXXXXXX	National Producer Number: XXXXXXXXXXXXXXXXXXX
Broker First Name:	Broker Last Name:
Assigned QHP ID:XXXXXXXXXXXXXXXXXXXX	eHealth Plan ID: XXXXXXXXXXXXXXXXXXXXXXXXX
Qualified Health Plan Name:	

Total Premium Amount: $XXX.XX	Total Amount Owed: $XXX.XX	APTC Amount: $XXX.XX

Contact Information:

Contact Person Last Name:
Contact Person First Name:
Contact Person Middle Name:
Contact Person Suffix Name:
Address: Apt./Suite/Unit:
City:
State: Zip Code:

Additional Information: (Names of each enrollee being covered and paid for)

1. Jane Doe 1
2. Jane Doe 2
3. Jane Doe 3
4. Jane Doe 4
5. Jane Doe 5
6. Jane Doe 6
7. Jane Doe 7
8. Jane Doe 8
9. Jane Doe 9
10. Jane Doe 10
11. Jane Doe 11
12. Jane doe 12

Proposed Coverage Effective Date: MM/DD/YYYY