Medicare Information Sheet

Date Recieved:

Name _____ ***Date*** _____

Address _____

City _____ ***State*** _____ ***Zip Code*** _____

Email _____ ***Phone #*** _____

Cell # _____ ***Do you text message?*** ☐***Yes*** ☐***No***

Date of Birth _____ ***# In Household*** _____ ***SS#*** _____

Height _____ ***Marital Status:*** ☐***Single*** ☐***Married***

Weight _____ ***Tobacco (all types):*** ☐***Yes*** ☐***No***

MEDICARE SUPPLEMENT PLAN REVIEW

What company is your plan with?

_____

What plan do you have? Plan (G / F / N)

What is your current monthly cost?

$_____

MEDICARE INFORMATION

FULL NAME:

_____

MEDICARE NUMBER:

_____

HOSPITAL (PART A) _____/ _____/ _____

MEDICAL (PART B) _____/ _____/ _____

WHAT WOULD YOU LIKE TO DISCUSS?

(Check all that apply)

- ☐ How medicare works
- ☐ Medicare Enrollment
- ☐ Social Security Enrollment
- ☐ Rx Drug Plans
- ☐ Medicare Supplements
- ☐ 401k Rollovers
- ☐ Annuities & Retirement
- ☐ Life Insurance
- ☐ Vision or Dental

How did you hear about us? _____

WHICH TYPE OF APPOINTMENT DO YOU PREFER?

(Please select one or both options)

☐ ***Phone Meeting***

☐ ***Video Meeting***
(Computer or Tablet with Camera & Microphone)