

Information Form for Medicare Eligible Individuals

Please complete one form per individual to be insured.

Date _____ Person Completing Form _____

First Name _____ Last Name _____ Birthdate _____

Home Phone _____ Cell Number _____ Smoker ☐ Yes ☐ No

Please circle preferred number. Also share whose cell number you provide.

Address _____

County _____ E-Mail _____

Primary Care Doctor _____ Dentist _____

Optometrist _____ Other Specialist _____

Preferred Hospital _____ Preferred Pharmacy _____

Please list all prescription medications for those to be insured on the reverse.

Medicare: ☐ Supplement ☐ Advantage ☐ Part D (prescription) Eligible Dates: Part A ____/____/____ Part B ____/____/____

Medicare Number (if applicable) _____

Current Insurance Company: (if NONE please put end date of last) _____

If you have Medicaid please include Member ID otherwise put NA _____

Current Insurance/Employer: _____ End Date: _____
(if applicable, otherwise please put NA)

Information you want us to know _____

Please list all prescription medications (not over the counter). Be sure to include aerosols/inhalers, creams/ointments, insulin, durable medical equipment (CPAP/oxygen), and other injectables.

[illegible]