

GENERAL INFORMATION



Get help finding the right plan for you. Contact me today.
Licensed Sales Agent
917-660-6267 jillstern65@gmail.com

START DATE OF NEW INSURANCE? _____ Election Period _____

PLAN NAMES: _____

TODAY'S DATE: _____ APPLICATION DATE _____ BIRTH DATE: _____

NAME: _____ SPOUSE: _____

ADDRESS: _____ ZIP CODE _____

PHONE 1: (for app) _____ Phone 2: _____

EMAIL _____ Referred By??? _____

Reason you contacted me? _____

MEDICARE NUMBER: _____

Medicare Part A start date: _____

Medicare Part B start date: _____

MAPD PCP NAME _____

MAPD PCP ID _____

PCP TEL #: _____

AARP MEMBER # (for supp only) _____

CURRENT INSURANCE CO : _____ START DATE: _____
END DATE: _____

DOCUMENTS EMAIL PAPER:

Member of EPIC? EPIC # _____ (Over 65 only) EPIC Start Date? _____

PLAN PREMIUM how do you want to pay for it? SOCIAL SECURITY Coupon Book EFT

Name of Bank _____ Routing# _____

Account # _____

MEDICAID? Y/N _____ If so, what is your **Medicaid #?** _____

