WELL-LIFE GROUP
INSURANCE COMPANY

Name: _____ Plan to Represent: _____

Phone: _____ Email:_____

HEALTHCARE PLAN MATERIALS

Member Enrollment Booklet Pharmacy/Provider Directory

Formulary Over-the-Counter OTC

Star Rating sheet Others:

Address: _____

City: _____ state:_____ zip: _____

How long have you been living in this address: _____

Client Name: _____

Present Plan:_____

Medicare #: __ __ __ -__ __ __ - __ __ __ __

A ___/___ /_____

B ___/ ___/ _____

D.O.B: ___/_____/_____

LIS: ____Y ____N percentage: _____%

Medicaid: Y___ N ___ # _____ FULL___ PARTIAL___

Do you have End Stage Renal Disease? ____Y _____N

Other SEP (add all the SEP that Apply):

_____

_____

Has your doctor or other health care professional diagnosed you with any Chronic condition

Y___ N ___.

1_____ 2._____ 3._____ 4._____

DOCTOR NAME: _____

Address: _____suite_____

City: _____state: _____ zip: _____

Phone #: (____)_____--_____

Note:_____

_____

_____

_____

_____

_____

_____

(GIVE BUSINESS CARD AND ASK FOR REFERALS)

Signature: _____ date: _____