Experience Health

2020 Medicare Educational Seminar

Name:____

Gender: M or F DOB: ______________________________ Age: _________________________

Spouses Name: ____ Spouses' DOB: __________________

Address:____

City, State, Zip: ____ County: _______________________

Home Phone:________________________________Cell Phone:_____________________________________

Email:____

Enrolled in Medicare: Y or N If yes, Medicare effective dates: A_____________ B_____________

Already enrolled in a Medicare plan? If yes, Company: ______________________________________

Plan Type: _______________________Premium: ______________Effective Date: ________________

Veteran: Y or N Do you use VA for: Healthcare: Y or N / Prescriptions: Y or N

Medicaid: Y or N If yes, are you on a Spend Down: Y or N Social Security/SSD: Y or N

Employed: Y or N If Yes, expected retirement date ____________ Group Insurance: Y or N

PLEASE CHECK ALL THAT APPLY:

_____Yes, please contact me to schedule a free Medicare consultation.

_____ I am not eligible for Medicare at this time. Please contact me when I become eligible.

_____ I know someone needing assistance with Medicare. We will contact you to get their contact information.

_____No, I am not interested at this time.

Best Day / Time to Contact: ____

Additional Comments: ____

Signature:____Date:___________________________