Contact me about Medicare plans

Name: _____

Address: _____

City: _____ State: _____ ZIP:_____

Telephone: _____

Email: _____

Currently Medicare eligible:

❑ Yes ❑ No If no, when will you be eligible:_____

❑ If I'm not eligible to enroll before open enrollment begins on October 15, contact me between October 1 and December 7

Interested in plan information for:

- ❑ Prescription drug plans
- ❑ Supplement plans
- ❑ Medicare advantage plans
- ❑ Ancillary products (i.e., dental, vision, hearing, cancer, hospital indemnity)

(plan availability may vary by location)

We may be able to save you money

Fill in the following information.

	In network (Y/N)	Copay/coinsurance
Primary care physician		
Specialist		
Specialist		
Specialist		
Specialist		
Prescription		
Prescription		
Prescription		
Prescription		
Prescription		
Prescription		

By giving my contact information, I agree to allow a licensed sales representative to contact me about information related to Medicare options or to enroll in a plan.

Signature: _____ **Date:** _____

I understand that the person who will be discussing plan options with me may be compensated based on my enrollment in a plan.