

Agent Name: Jeffrey J. Rood

Address: 428 Union Avenue, 1st Floor

Kittanning, PA 16201

Phone: 724-545-6270

Dear _____,

To find the best Medicare Supplemental/Advantage Plan with the best benefits and the best price in your area, please fill out this questionnaire and return it to me, in the self-addressed, stamped envelope, along with the signed Scope of Appointment.

Please copy your prescription drugs directly from the containers, including any generic names.

If you have any questions or need assistance filling out this form, please contact me at (____) ____ - ____.

Who is your Primary Care Physician, the group name, address and phone number?

Hospitals that you would want access to receive care from,
if needed?

1. _____
2. _____
3. _____
4. _____

Specialists – Name, Group Name, address and phone
number:

1. _____

2. _____

3. _____

4. _____

5. _____

Prescription Drugs:

Name	Dosage	Strength
(Brand/Generic)	(Caps, tablets, daily, etc.)	(milligrams, drops, etc.)
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		
7. _____		
8. _____		
9. _____		
10. _____		
11. _____		
12. _____		
13. _____		
14. _____		
15. _____		

My new Medicare #: _____

Thank you for taking the time to complete this questionnaire so that I can research the best options for your medical needs and lifestyle.

I look forward to meeting with you soon.

Best regards,

Use this space for any additional information: