**Permission to Contact Form**

By filling out this form, you are granting permission for a licensed insurance agent from Amicus Path Insurance to contact you regarding Medicare insurance options.

**Your Information:**

* **Full Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Email Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Preferred Contact Method (check one):**
  + ☐ Phone call
  + ☐ Email
  + ☐ Text message

**Consent:**

I understand that by providing the information above, I am requesting a licensed insurance agent to contact me by phone, email, or text message to discuss Medicare insurance plan options. I acknowledge that this request for contact is not an obligation to enroll in a plan, and that the agent may contact me even if I am on a government do-not-call list.

☐ I consent to be contacted by a licensed agent.

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_