



*Providing Service & Establishing Relationships!*

## **WE ARE YOUR MEDICARE TEAM!**

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

E-Mail: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

### YOUR CURRENT COVERAGE

**TURNING 65** - When: \_\_\_\_\_

**CURRENTLY ON A MEDICARE SUPPLEMENT:** Carrier: \_\_\_\_\_

Premium: \$ \_\_\_\_\_ Plan Type: \_\_\_\_\_ (Ex. Plan F, G, N, C, etc)

**CURRENTLY ON A MEDICARE ADVANTAGE:** Carrier: \_\_\_\_\_

Premium: \$ \_\_\_\_\_ Plan Type: \_\_\_\_\_ (Ex. MA / MAPD - PPO, HMO, PFFS, etc)  
Cover Prescriptions? Networks

**LEAVING GROUP INSURANCE** - When: \_\_\_\_\_

### RATING / HOUSEHOLD DISCOUNT

TOBACCO USE:  YES  NO MARRIED:  YES  NO

### MEDICAL QUESTIONS

*If you're TURNING 65 or LEAVING GROUP INSURANCE, you don't need to answer the following...*

**1. In the past 2-5 years have you received treatment or therapy for any of the following:**

Y  N **HEART** - heart attack, heart disease or surgery, Atrial Fibrillation

\_\_\_\_\_

Continued: In the past 2-5 years have you received treatment or therapy for any of the following:

Y  N **CANCER** - any type of internal cancer

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Y  N **PARKINSON'S DISEASE**

Y  N **ALZHEIMER'S DISEASE / DEMENTIA**

Y  N **RHEUMATOID ARTHRITIS**

Y  N **CHRONIC OBSTRUCTIVE PULMONARY DISEASE "COPD"**

**2. ARE YOU DIABETIC?**  Y  N

a. Are you taking 50 units or more of insulin daily?  Y  N

b. Are you taking more than 2 medications - insulin or oral  Y  N

c. If Diabetic, how many blood pressure meds are you taking? \_\_\_\_\_

*Don't Count "Water Pill" as a Blood Pressure Medication*

**3. Have you been hospitalized 2 or more times in the past year?**  Y  N

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**4. Have you been advised by a physician to have surgery, medical tests, treatment or therapy (includes physical therapy) that has not been performed?**  Y  N

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**5. Do you take prescription medication?**  Y  N

*If yes, please complete your medication list...*

	MEDICATION	DOSAGE	TREATMENT FOR....
1			
2			
3			
4			
5			
6			
7			
8			

**WHAT PHARMACY WOULD YOU LIKE TO GET YOUR PRESCRIPTIONS?**

Pharmacy Choice 1: \_\_\_\_\_ Pharmacy Choice 2: \_\_\_\_\_

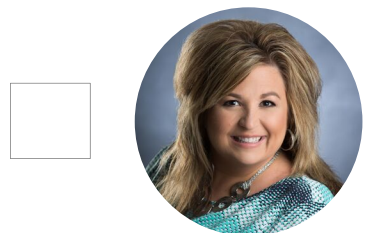
Do you like to use Mail Order?  Y  N

**ANY ADDITIONAL INFORMATION YOU WOULD LIKE TO SHARE WITH US?**

Please Fax form to: 888-959-3096 or E-Mail: insurance@tonyalegrande.com

..... OFFICE USE ONLY .....

Scheduled with Agent:



**Tonya  
LeGrande-Labenz**



**Dorothy  
Davenport**

Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_

**Appointment Checklist**

- Scheduled in Agent's Calendar
- E-Mail for to Agent & Support Staff
- Sent Client E-Mail Reminding of Appt.
- Information entered into Agency Bloc