Tonya LeGrande & Associates, LLC

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

_____

☐ 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

☐ Sent Client E-Mail Reminding of Appt.

☐ E-Mail for to Agent & Support Staff

☐ Information entered into Agency Bloc