AARON YZAGUIRRE
INSURANCE SERVICES
Medicare Beneficiary Intake Sheet

Full Name: _____ DOB: _____

Address (No P.O. Boxes): _____
(Number/Street) (City) (State) (Zip Code)

Phone: _____ Email: _____

Have you recently or are you planning to move to a new county of residence? Y ☐ N ☐ Move Date: _____

Medicare Number (all letters in lower case): _____

Part A Effective Date: _____ Part B Effective Date: _____

Are you currently enrolled in employer-based healthcare? Y ☐ N ☐ Ending Date: _____

Do you have any pending surgeries, procedures or imaging already scheduled? Y ☐ N ☐ Date:_____

Are you or your spouse a veteran of the Armed Forces? Y ☐ N ☐ If yes, do you have: TFL ☐ VA ☐ Both ☐

Authorized Representative's Name: _____
(Optional)

Phone: _____ Relationship to insured? _____
(Optional) *(Optional)*

Please fill out the highlighted fields with your prescription details below, if applicable.

Prescription Drug Name *(Ex: Metformin)*	**Dosage** *(Ex: 500 mg)*	**Frequency** (Ex: 2x daily)

Please fill out the highlighted fields with your doctors details below, if applicable.

Doctor's Name:	Provider ID:	Specialty:	Network:

I verify that to the best of my knowledge, all of the information provided is true and complete. I also agree that Aaron Yzaguirre is now authorized as my agent to enroll me into the below stated plan. I further understand that I may only change plans during qualifying enrollment periods and will contact my agent regarding any changes to my doctors, prescriptions or health status as soon as I am able.

Insured Signature: _____ **Date:** _____

Agent Signature: _____ **Date:** _____ **Time:** _____

For Office Use Only

Social Security Income: $_____

Employment Income: $_____

SS Disability Income: $_____

Self- Employment: $_____

Pension: $_____

Asset Value: $_____

Total Monthly Income: $_____

Medicaid? Y ☐ N ☐ Level_____

Medicaid #: _____

LIS Extra Help? Y ☐ N ☐ Level_____

Disabled? Y ☐ N ☐ Diabetes? Y ☐ N ☐

CSNP? Y ☐ N ☐ ESRD? Y ☐ N ☐

CHF? Y ☐ N ☐

Former Plan: _____ **Ending Date:** _____

New Plan: _____ **Effective Date:** _____