Consultation Form

MEETING DATE:

AGENT:

Name:_____

Address:_____

City State Zip:_____

County: _____

Phone:_____

Email:_____

PLAN CHOSEN: _____

EFFECTIVE DATE: _____ PREMIUM: _____

SOA CONFIRMATION #:_____

APP CONFIRMATION #: _____

DOB: _____

Medicare ID: _____

Part A Date:_____

Part B Date:_____

Are you/spouse currently employed? Y / N

Do you qualify for Extra Help/Medicaid? Y / N

If yes, Level/Medicaid ID#:_____

Any VA/TRICARE Coverage? Y / N

If yes, type/VA ID#:_____

Do you travel often? Y / N

PCP: _____

# of visits per year :_____

1.Specialist: _____

# of visits per year :_____

2.Specialist: _____

# of visits per year :_____

3.Specialist: _____

# of visits per year :_____

Current Coverage

MAPD A&B ONLY MED SUPP EMPLOYER

Carrier: _____

Premium:$_____

Rx Plan Carrier: _____

Rx Plan Premium : $_____

Rx OOP Approximate Cost :$ _____

Preferred Pharmacy:_____

TOTAL COST: $_____

3 things you like about current coverage:

1. _____
2. _____
3. _____

What are some things you'd like to see in a new plan?

_____

_____

Do you mind copays/deductibles? Y / N

Any upcoming Treatments/Conditions? Y / N

Plan Recommendation

Plan Recommended:: _____ Premium: $_____

PCP In Network? Y / N Specialist(s) In Network? Y / N Summary of Benefits(go over):

Notes:

Spouse Consultation Form

MEETING DATE:

SALES SPECIALIST:

Name:_____

Address:_____

City State Zip:_____

County: _____

Phone:_____

Email:_____

PLAN CHOSEN: _____

EFFECTIVE DATE: _____ PREMIUM: _____

SOA CONFIRMATION #:_____

APP CONFIRMATION #: _____

DOB: _____

Medicare ID: _____

Part A Date:_____

Part B Date:_____

Are you/spouse currently employed? Y / N

Do you qualify for Extra Help/Medicaid? Y / N

If yes, Level/Medicaid ID#:_____

Any VA/TRICARE Coverage? Y / N

If yes, type/VA ID#:_____

Do you travel often? Y / N

PCP: _____

# of visits per year :_____

1.Specialist: _____

# of visits per year :_____

2.Specialist: _____

# of visits per year :_____

3.Specialist: _____

# of visits per year :_____

Current Coverage

MAPD A&B ONLY MED SUPP EMPLOYER

Carrier: _____

Premium:$_____

Rx Plan Carrier: _____

Rx Plan Premium : $_____

Rx OOP Approximate Cost :$ _____

Preferred Pharmacy:_____

TOTAL COST: $_____

3 things you like about current coverage:

1. _____
2. _____
3. _____

What are some things you'd like to see in a new plan?

_____

_____

Do you mind copays/deductibles? Y / N

Any upcoming Treatments/Conditions? Y / N

Plan Recommendation

Plan Recommended:: _____ Premium: $_____

PCP In Network? Y / N Specialist(s) In Network? Y / N Summary of Benefits(go over):

Notes: