

# Spark Prospect Form

*save time and ask your agent for the digital version*

Date \_\_\_\_\_ Agent Name \_\_\_\_\_ Permission to contact: Yes / No

Language: English / Spanish / Mandarin / Other \_\_\_\_\_

Source: Referral / Event / Call Center / Mailer / Carrier / Other \_\_\_\_\_

Reason for meeting: Turning 65 / Loss of employer coverage / Gained/lost low income subsidy /  
On disability for 24mo / Moved residency / 5-star plan interest / Other \_\_\_\_\_

## Your contact details

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ Date of Birth \_\_\_\_\_

Email \_\_\_\_\_

Medicare # \_\_\_\_\_ Effective dates for: Part A \_\_\_\_\_ Part B \_\_\_\_\_

Medicaid # \_\_\_\_\_ Medicaid Level \_\_\_\_\_

Current Plan \_\_\_\_\_

## Your health information

Conditions: End-stage renal disease Diabetes Heart Failure Blood Thinner  
*select all* Hearing loss Vision impairment Major dental work

## Doctors

| Name | Address | Type |
|------|---------|------|
|------|---------|------|

## Medications

| Medicine Name | Dosage | Quantity | Frequency |
|---------------|--------|----------|-----------|
|---------------|--------|----------|-----------|