MEDICARE PART D & SUPPLEMENTAL INSURANCE INFORMATION

Please fill out this information sheet and return it to the Senior Center Reception Desk.

A Medicare consultant will process your information and call you to set up an appointment.

I would like to discuss the following with a Med	licare consultant:
Medicare Part D Plan	
Medicare Supplement Plan	
Other	
Name	Date of Birth
Address	City/Zip
Phone	County``
	•
Name of 2014 Part	D Insurance Plan
(Company plus any description	such as Basic, Choice, Premier)
Monthly 2014 Premium	
Name of current Medicare Supplement Plan (without drug coverage)	Name of current Medicare Supplement Plan (with drug coverage)
(Company plus any description such as Basic, Essentials, Premier)	(Company plus any description such as Basic, Essentials, Core)
Monthly Premium	Monthly Premium

LIST PRESCRIPTIONS ON BACK OF INFORMATION SHEET

Pharmacy of Choice_

PRESCRIPTION DRUG LIST

Please list the prescription drugs you are now taking. Do NOT include over the counter medications. If you have a list from your pharmacy, you may attach it to the form. Please be specific about the dosage and how many times a day or month you take each drug. If taking eye drops or using an inhaler or any other drug in non-tablet form, please include the size of the bottle and whether it is a liquid, gel, spray, etc. in the Dosage column.

<u>Medications</u>		<u>Dosage</u>		Frequency (Example: 2x-day or 2x-week)
				
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SHIP Volunteer		Date	Time Spen	nt
Drug List ID		Drug List Password Date	•	
Name of Part D Plan if enrolled				
Name of Supplemental Plan if enrolled				
NOTES:				