MEDICARE SUPPLEMENT / MEDICARE ADVANTAGE
INFORMATION SHEET

Medicare.Gov User: _____ **Password:** _____

Security Answer: _____

Full Legal Name: _____

Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Address: _____ **City:** _____

State: _____ **Zip Code:** _____ **County:** _____

Home Phone: _____ **Cell Phone:** _____

Email Address: _____

Currently on SS: _____ **If not, when do you plan to?** _____

Current Income: _____ **Currently Employed?** _____

Currently on Medicaid? _____ **If so, Medicaid #?** _____

Gender: _____ **DOB:** _____ **Birth State:** _____

Age: _____ **Tobacco:** _____ **Live w/ Anyone?** _____

Medicare Card Info: Medicare Claim #: _____

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

Current Health Plan: Company: _____ **Plan Type:** _____

Premium: $_____ **Effective Date:** _____

Health Condition	Date of Onset	Outcome

Current Height/Weight: _____/_____ **Doctor's Name:** _____

Last Visit to Doctor: _____ **Reason:** _____

PRESCRIPTION DRUG
PLAN INFORMATION

Drug Name	Dosage	Frequency	1-month or 3-month supply	Pharmacy or Mail Order

Name of Preferred Pharmacy: _____

Address: _____

Current Prescription Drug Provider: _____

Premium: $ _____ **Co-Pay:**_____

How do you want to pay for your monthly premium?

☐ **Social Security Deduction** ☐ **Checking/Savings Account** ☐ **Coupon Booklet**