# Contact me about Medicare Plans

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

Email: _____

**Interested in plan information for:**
☐ Prescription drug plans
☐ Medicare Supplement plans
☐ Medicare advantage plans
☐ Ancillary products (i.e., dental, vision, hearing, hospital indemnity)
*(plan availability may vary by location)*

**Currently Medicare Eligible:**
☐ Yes ☐No If no, when will you be eligible:
☐ If I'm not eligible to enroll before open enrollment begins on October 15, contact me between October 1 and December 7

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**We May be able to save you money**
Fill in the following information.

| | **In Network (Y/N)** | **Copay /CoInsurance** |
|---|---|---|
| Primary Care physician | | |
| Specialist | | |
| Specialist | | |
| Specialist | | |
| Specialist | | |
| Prescription | | |
| Prescription | | |
| Prescription | | |
| Prescription | | |
| Prescription | | |
| Prescription | | |

By giving my contact information, I agree to allow a licensed sales representative to contact me about information related to Medicare options or to enroll in a plan.

**Signature:** _____ **Date:** _____

I understand that the person who will be discussing plan options with me may be compensated based on my enrollment in a plan.