STEINLAGE INSURANCE AGENCY

Instructions

Please fill out the following form to the best of your capabilities. Please feel free to copy & share with your friends & family. We will run a free analysis when the form is returned. Return by email to info@steinlageinsurance.com or via fax (636)625-1529. Call us with any questions at (636)561-5060.

Review Information

Name:		Street Address Including City, State, and Zip Code	
Telephone:		Medicare ID Number (MBI):	
Birthdate:		Part A Effective Date:	
Email:		Part B Effective Date:	
Advisor or referred by:		Current Broker: (**Circle One**)	Margo/Eric/Karl/NA N/A

Part D Plans:

Part D Plan Company Name: (i.e. AARP Rx, SilverScript)		**Part D** Plan Name: (i.e. Saver Plus, Choice, Preferred)	
Preferred Pharmacy:			

Medicare Supplement Plans: **Medicare Advantage Plans:**

Medicare **Supplement** Plan Letter: (A, B, C, D, F, G, K, L, M, N)		**MAPD** Plan Type: (i.e. HMO, HMO/PPO)	
Medicare **Supplement** Insurer: (i.e. Anthem, AARP)		**MAPD** Plan Company Name: (i.e. AARP, Anthem)	
Medicare **Supplement** Rate & Effective Date/Date Policy Began:		**MAPD** Rate:	

Current Prescriptions: (Do NOT include over the counter (OTC) meds)

Drug Name	Dosage (mg, mL)	Modifier (XL, XR, CL)	# per day	Qty per Mth	Tablet/Capsule Ointment/Cream	Mail Order or Retail
For Example: *Lisinopril*	*20 mg*		*1*	*30*	*Tablet*	*Retail*