2024 AEP Review Form To MAIL- PDF Version- Print 2 Sided!

PLEASE HAVE THE FOLLOWING ITEMS AVAILABLE TO COMPLETE AND SUBMIT THE FORM:

- Red, white, and blue Medicare card and information regarding your current Medicare coverage
- A list of your current medications and current physicians

****Each Individual Requesting A Review Must Complete A Separate Form****

1. Please Enter Your Contact Information (As displayed on your drivers license or other ID), Information About Your Current Broker, and Information About Your Referral Source .

Legal First Name: _____ Middle Name: _____ Legal Last Name: _____ Date of Birth: _____

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

County of Residence _____ Social Security # _____

Primary Phone # _____ Type of Phone # (Cell/ Home/ Work) _____

Email _____ Current Broker (Karl Steinlage/ Eric Steinlage/ Margo Steinlage/ Manny Adams/ Angela Windett) _____

2. Please Enter The Information Found On Your Red, White, And Blue Medicare Card

Name As It Appears On Your Medicare Card _____

Medicare Number (please do not include dashes) _____

Part A Effective Date _____ Part B Effective Date _____

3. If you have a Medicare Supplement Plan, Please Complete The Questions Below

What is the letter of the Medicare Supplement plan you currently have? _____

What is the name of your Medicare Supplement Insurer (Example: Anthem, AARP)? _____

How much do you pay for your current Medicare Supplement Plan (what is your current rate)? _____

What is the effective date of your current Medicare Supplement Plan (date the policy began)?

What is your Part D Drug Plan company name (example: WellCare, Humana, AARP UHC)?

What is your Part D Drug Plan name (example: Value Script, Choice, Preferred)?

4. If you have a Medicare Advantage Plan, Please Complete The Questions Below

What MAPD Plan type do you currently have (example: HMO, HMO/ PPO)?

What is the company name of your MAPD Plan (example: AARP, Anthem)

What do you currently pay for your MAPD Plan (rate)?

5. Please Enter All CURRENT Prescription Medications (Do NOT Include Over The Counter (OTC) Medications). PLEASE ATTACH A SEPARATE LIST IF NECESSARY-WE MUST HAVE THIS INFORMATION PRIOR TO THE AGENT'S REVIEW

Medications/ Prescriptions	NAME OF MEDICATION	DOSAGE	MODIFIER (XL/ XR/ CR/ CL/ Etc.)	MEDICATION TYPE	# PER DAY	# PER MONTH
Medication #1						
Medication #2						
Medication #3						
Medication #4						

6. Please Provide Your Current Provider/ Physician Information. PLEASE ATTACH A SEPARATE LIST IF NECESSARY-WE MUST HAVE THIS INFORMATION PRIOR TO THE AGENT'S REVIEW

PHYSICIAN INFORMATION	NAME OF PHYSICIAN	PHYSICIAN'S SPECIALTY	ADDRESS	ZIP CODE
Physician #1				
Physician #2				
Physician #3				

7. In the last 12 months, have you used any form of tobacco (including chewing tobacco, cigarettes, e-cigarettes, vaping, cigars, or a pipe)?

○ No- I Have Not Used Any Form Of Tobacco ○ Yes- I Have Used Some Form Of Tobacco

8. Please Enter The Name And Address Of Your Preferred Pharmacy

Pharmacy Name, Address, And Zip Code