

2025 AEP Review Form Hard Copy

Our agents at Steinlage Insurance Agency strive to provide a personalized experience for our clients. This information is requested to help research the best options. Our agents review this information to prepare in helping our clients navigate their insurance needs!

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

- Red, white, and blue Medicare card
- Information regarding your current Medicare coverage
- A list of your medications (dosages, type of medication, frequency of medication, and name of individual prescribed the medication)
- A list of your current physicians (name, address, zip code, and Phone #)
- Once completed please mail the form back to our new address: 1021 Peruque Crossing Ct, O'Fallon, MO 63366

****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	HOW OFTEN DO YOU GET A REFILL?
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

Once completed please mail the form back to our new address: 1021 Peruque Crossing Ct, O'Fallon, MO 63366 and we will be in touch with you no later than December 7th.