MediCare Pre-Enrollment Form

Bring this completed form to your appointment *Date* *Time*

Name _____ Birthdate _____ Age _____

Street _____ MediCare ID # _____

City _____ Zip _____ Email _____

☐ **Mailing address is same as my residence** Phone _____

Mailing Address _____ MediCare 'Part A' Effective Date: _____

City _____ Zip _____ MediCare 'Part B" Effective Date _____

☞List Prescriptions You Currently Use on the Back of this Page

Your MediCare Supplement Preference

☐ *Lowest Premium* ☐ *Lowest Deductible & Copays* ☐ *Not Sure What is Best for Me*

Your Current Supplement Plans

Medical Plan _____ Type _____ Premium _____

Prescription Plan _____ Type _____ Premium _____

Other Insurance _____ Type _____ Premium _____

Supplement Plans Elected

Medical Plan _____ Type _____ Premium _____

Effective Date _____ Payment Method _____

Prescription Plan _____ Type _____ Premium _____

Effective Date _____ Payment Method _____

Consultation Notes:

Client Source:

DCD Insurance Services 1123 Soquel Ave Santa Cruz, Ca 95062 O 831.423.8542 F 831.423.5714

Agents: Pamela Fugitt-Hetrick Robert Jaramillo (Se Habla Espanol) LaVyrne Lomas

List Prescriptions You Currently Use

☞Use the Exact Names as Printed on Prescription Label

My Preferred Pharmacy is: _____

Rx Name _____ Dose _____ Times per Day _____

Rx Name _____ Dose _____ Times per Day _____

Rx Name _____ Dose _____ Times per Day _____

Rx Name _____ Dose _____ Times per Day _____

Rx Name _____ Dose _____ Times per Day _____

Rx Name _____ Dose _____ Times per Day _____

Rx Name _____ Dose _____ Times per Day _____

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Rx Name _____ Dose _____ Times per Day _____

Comments & Questions for my Agent:

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