

# 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**

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 _____
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 _____
Rx Name _____	Dose _____	Times per Day _____
Rx Name _____	Dose _____	Times per Day _____

Comments & Questions for my Agent: