Questionnaire for Medicare Enrollment Products

Date: _____

Contact Information

- Your name: _____
- What Is your permanent or principal home address ? _____
- Is this the address on your Driver's License or DMV Identification Card ? Yes/No _____
  - If not, what is the address on your Driver's License? _____
- Your best contact phone #: _____
- Your best email address: _____

Eligibility for Medicare Plan/Policy

- Are you below 65? Yes/No: _____
  - If Yes, do you have Disability or ESRD Medicare eligibility? _____
- What is your Date of Birth? : _____
- Do you have Red & Blue Medicare Claims Card? Yes / No: _____
- Do you see both Part A and Part B on your Medicare Card ? Yes / No: _____
  - For Part A, what is the date on the Medicare Card : _____
  - For Part B, what is the date on the Medicare Card: _____
  - What is the Medicare Card Number ? _____
- Have you enrolled for Part D Prescription Drugs coverage ? Yes /No: _____
  - If NOT, do you plan to enroll by calling 1-800-633-4227 or www.Medicare.gov ? Yes /No: _____
  - If NOT, do you plan or have alternative to Part D enrollment coverage? Yes / No: _____

Group or Employment Related Medical Coverage

- Do you have any Group or Work sponsored medical coverage? Yes /No: _____
  - If Yes, what is it? _____
- Does your spouse cover you for medical insurance? Yes / No: _____
  - If Yes, what is it? _____
- Do you have Prescription Drugs coverage from your current plan or private insurance? Yes / No: _____
  - If Yes to above, is this coverage as good or better than Part D coverage you can get ? Yes / No:_____
  - If Yes to above, do you intend to keep your current coverage for Prescription Drugs? Yes /No: _____
  - If Yes to all above, please give its reference of your current coverage : _____
- Once enrolled in Medicare plan, will you or your spouse work? Yes /No: _____
  - If Yes, will you be taking Prescription Drugs coverage through your spouse's group plan? Yes /No : _____
  - If Yes to above, please give reference of your spouse's group plan: _____

_____

Current Medical Plan/Policy

- What kind of medical insurance plan you currently have? _____

- What are the monthly premiums you are paying? $ _____
- How long you have been having this current plan/policy? _____
- What is in your current plan that does not serve you well? _____

  _____

Current Primary Care Physician and Specialist in close proximity of your residence

- What is the name of the Cardiologist [specialist] that you see? _____
  - Is it important to you that you must continue to see the same Cardiologist ? Yes /No: _____
  - Are you flexible to change your Cardiologist if need be ? Yes /No: _____
- Do you see any other Medical Specialist? Yes /No: _____
  - If Yes, what is the name and specialty of this doctor? _____
  - Are you flexible to change this Specialist if need be ? Yes /No: _____
- What is the name and specialty of the Primary Care Physician you currently see? _____
  - Does your PCP coordinate your care with the specialists you see? Yes / No: _____
  - How often do you see your PCP on annual basis? _____
  - Are you flexible to change this PCP if need be? Yes /No: _____
- What will your preference be to visit medical providers and facilities within the US from choices below ?
  - Anywhere, any provider, any medical facility who accept Medicare ? Yes /No: _____
  - Stay within an insurance carrier's networked healthcare providers? Yes / No: _____
  - Stay within carrier's network with option to see non-network providers ? Yes /No: _____
- What is desirably farthest distance in miles from your home to see your doctors and visit hospital? _____

Coverage During Travel and Stay Away from Home

- On an annual basis, how often you travel away from your residence *within your State* ? _____
- On an annual basis, what is your typical stay in *Out-of-State places within the U.S*. ? _____
- When you need to see physicians and/or hospital facilities during your travel and stay in *Out-of-State* places in *non-emergency situations* within the U.S., what would your preference be from choices below:-
  - Visit any doctor and/or visit any hospital anywhere who accepts Medicare? Yes / No: _____
  - Visit doctors and hospitals within carrier's networks ? Yes / No: _____
  - Visit doctors and hospital who may be *out-of-carrier's networks* ? Yes / No: _____
- Do you do international travels and stay away from the U.S. including cruises ? Yes /No _____
  - If Yes, what is the typical annual duration of your international travel and stay abroad ? _____
  - Would international travel insurance be of interest to you? Yes /No: _____

Your Health Status

- How is your health ? : Very Good/Good/Fair/Tolerably Ok/ Poor ? _____
- Do you have any pre-existing medical condition? Yes /No: _____
  - If Yes, what is it and since when? _____

Your Medications Status

- How'd you characterize your consumption level of prescription medications ?

- Heavy / Medium /Light /Occasional / No Medication: _____
- What is roughly your current annual budget for prescription medications? $_____
- Do you have list of your prescription medications that you regularly take? Yes / No: _____

Special Needs and Requirements

- Do you get any help from Social Security Administration? : Yes /No: _____
  - If Yes, what help do you get ? _____
  - Do you have Medicaid Card ? Yes / No: _____
- Do you have any chronic or serious illness that needs special medical care ? Yes /No: _____
  - If Yes, what is it? _____

Enrollment Election Period

- When would you like your new Medicare plan or policy to be effective? : _____

What Type of Plan and Feature Would You Like to Discuss ?

Medicare Advantage with Prescription Drugs coverage:

- Preferred Provider Organization [PPO] _____
- Health Maintenance Organization [HMO] _____
- Private Fee For Service [PFFS] _____

Prescription Drugs Plan [stand-alone PDP] _____

Medicare Supplement _____

Premium Payments

What is your desirable range premium payments per month ? $_____ to $_____

NOTES

_____
_____
_____
_____
_____

Contact:

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