

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 Ayde Camacho (Se Habla Espanol) Leslie Cole

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 _____
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: