ANNUAL ENROLLMENT PERIOD MEDICARE REVIEW SHEET(OCT15- DEC 7 TH)

Please circle your choices

Drug Name or None	Circle one	Dosage per day
	Generic / Name Brand	
	Generic / Name Brand	
	Generic / Name Brand	
	Generic / Name Brand	
	Generic / Name Brand	
	Generic / Name Brand	
	Generic / Name Brand	

Current Medicare Plan	Insurance Carrier	Plan Name
		Medicare Supplemental or Medicare Advantage
Current Premium Satisfied or not ?	$ ____________ per month Yes /No	Month enrolled
Current Part D - RX- PrescriptionPlan		
Current Premium Satisfied or not	$ ____________ per month Yes /No	
Preferred Pharmacy:		City

Please circle the one's you are intersted in reviewing or need:

Medicare Supplemental Plan	Medicare Advantage Plan	Part D Plan	Dental /VisionPlan
Travel Insurance	Life Insurance Plan	Long Term Care	Final Expense Plan

Name:	Email:
Address:	Phone: Date Of Birth: