

MEDICARE INFORMATION FORM

Please Fax back to: Elite Insurance Associates @ 904-527-1318

Preferred Agent (Optional): _____

Medicare ID #: _____ Part A Effective Date: _____ Part B Effective Date: _____

APPLICANTS GENERAL INFORMATION

First Name: _____ MI: _____ Last Name: _____

Social Security #: _____ Age: _____ DOB: _____ Gender: _____

Home Address: _____ City: _____ State: _____

County: _____ Zip: _____ Tobacco Usage (yes or no): _____

Phone Numbers: Best: _____ Secondary: _____

E-mail Address: _____

What coverage do you currently have in place? _____ End Date: _____

A separate Scope of Appointment and Permission to Contact Form has been provided and must be signed and returned to our office or your Agent. These forms will be retained for 10 years, per CMS Medicare guidelines.

MEDICATIONS & DOCTORS

Medications Name: _____ Dose: _____ How Often Taken: _____ Tablet / Capsule?

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Preferred Pharmacy: _____

***Not Necessary if you are doing a RX review or currently have a Medicare Supplement Plan.*

Physicians: _____



Elite Insurance Associates

1710 Shadowood Lane, Unit 240 Jacksonville, Florida 32207 904-527-1304 - www.eiafl.com

Sep. 29, 23

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Client does not need to fill out the grid below. We will review this during your appointment.

Plan Name	Premium	Publix	CVS	Walgreens	Walmart	Mail Order

For Medicare Clients per CMS guidelines effective October 1st, 2022: “We may not offer every plan available in your area. Currently we represent 10 Medicare Organizations that offer over 44 different plan options in your area. Please contact Medicare.gov or 1-800-MEDICARE or your local State Health Insurance Program (SHIP) to get information on all your options.”



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