(817) 613-1098

JB Gross Insurance Agency LLC

Fax (817) 613-1360

www.jbgross.com

Medicare Information Sheet

Full Name:_____ Referred By: _____
Requested Effective Date:_____ Primary Contact Person for Additional Information:_____
Gender:☐ Male/ ☐ Female DOB:_____ Tobacco Use:☐ Yes/ ☐ No Height:_____ / _____ Weight:_____lbs
Street Address: _____City:_____ Zip Code:_____County:_____
E-mail Address:_____ Single☐ Married:☐ Other: _____
Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____

Types of Coverge to be Quoted

☐ Medicare Supplement ☐ Prescription Drug Plan (PDP/RX) ☐ Medicare Advantage HMO ☐ Medicare Advantage PPO

Reason for Enrolling: ☐ Initial Enrollment Period (IEP) ☐ Annual Enrollment Period (AEP) ☐ Special Enrollment Period (SEP)

Needs Assessment: Is there a family memeber, friend, or Power of Attorney that helps you make decisions on your medical care?
☐ YES / ☐ NO If yes, who? _____

Current Coverage: Carrier's Name:_____ Date Coverage Ends: _____
Are you an AARP Member? ☐ YES / ☐ NO Do you have End Stage Renal Disease (ESRD)? ☐ YES / ☐ NO
Are you on Medicaid? ☐ YES / ☐ NO Do you get extra help through Social Security? ☐ YES / ☐ NO What kind?
_____

Provider Check: List your current *PHYSICIANS*, *LABORATORY*, and *HOSPITAL* information*

PHYSICIAN or FACILITY NAME	PROVIDER TYPE	PHONE NUMBER	CITY & ZIP CODE

Pharmacy Check: List your preferred *PHARMACY* information (mail order pharmacies can be listed)

PHARMACY NAME	PHONE NUMBER	CITY & ZIP CODE

Prescription Check: List *ALL PRESCRIPTIONS*, include *TYPE* (Capsule/Tablet/ Liquid/Etc.), *DOSE*, & *TIMES TAKEN PER DAY**

**Print additional sheets if needed for Provider or Prescription Information*

_____ _____
Signature Date

**********Agent Office Use Only**********
Date Submitted:_____ Submitted Via: ☐ Email ☐ Fax ☐ In Person ☐ Mail Information taken by:_____
Notes:_____
_____
_____