REICHERT
FINANCIAL

DATE/TIME:

REFERRED BY:

CURRENT/PRIOR PLAN INFORMATION ☐ INDIV. ☐ GROUP ☐ OTHER

- ☐ MEDICAL _____ MONTHLY PREMIUM $ _____
- ☐ PRESCRIPTION DRUG _____ MONTHLY PREMIUM $ _____
- ☐ DENTAL _____ MONTHLY PREMIUM $ _____
- ☐ VISION _____ MONTHLY PREMIUM $ _____

MEDICARE PLAN REQUEST FORM

Contact Information: *(SOCIAL SECURITY AND MEDICARE NUMBERS ARE **NOT** REQUIRED)*

FULL LEGAL NAME:

EMAIL ADDRESS:

PHONE NUMBER: ☐ HOME ☐ CELL

DATE OF BIRTH

SMOKER? Y / N

SOCIAL SECURITY #

TURNING 65? Y / N

MEDICARE #

EFFECTIVE DATE: (PART A)

EFFECTIVE DATE: (PART B)

Primary Residence / Address:

ADDRESS

CITY, STATE

ZIP

Secondary Residence / Address: *(IF APPLICABLE)*

ADDRESS (INCLUDING CITY, STATE, ZIP):

Current Doctors / Physicians

PLEASE LIST: NAME, HOSPITAL, SPECIALIZATION

Medicare Part D: *(IF APPLICABLE)*

If you are requesting information regarding Medicare Part D...
Please complete this section about your current medications.

PREFERRED PHARMACY

PREFER MAIL ORDER? Y / N

NAME(s) OF PRESCRIPTION (TAB or CAP, ER, SR, etc)	DOSAGE	QUANTITY / MONTH
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FOR MORE INFORMATION CONTACT US:
Laura Kelley | laura@reichert-financial.com | (419) 931-0749

REICHERT FINANCIAL SERVICES
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