

Date: _____ **Personal Information Sheet (one per person)** Referred by: _____

Name _____ DOB _____ Phone _____

Address _____ City _____ State _____ Zip _____

County _____ Email _____ Tobacco Use last 12 months? _____

Marital Status: ☐ Married ☐ Single, Live Alone ☐ Single, Live With Someone

What health coverage do you currently have? (Mark box that applies):

☐ Individual ☐ Employer ☐ Retiree Plan Name _____ Drug Coverage Included? _____

Do you have an HSA (Health Savings Account)? yes/no _____

☐ Medicare Advantage Plan Name _____ (on your Insurance Card)

☐ Medicare Supplement Company Name _____ Plan(F, G, etc.) _____ (on your Insurance Card)

AND Plan Name of Current Prescription Drug Coverage _____ (on your Insurance Card)

Do you have Medicare?: ☐ Part A ☐ Part B ☐ Mark here if you have a **MyMEDICARE.gov** account set up

Veteran? (yes/no) _____ Interested in a Plan with Health Club Membership? (yes/no) _____

Current Pharmacy Name (VERY IMPORTANT) _____

☐ Mark here if you take NO medications **OR** ☐ My current medication list is attached (form provided)

NOTE: Some plans have Doctor networks, we want to check to see if your docs accept various plans

Primary Care Doctor _____ Phone _____

Dentist/Practice _____ Phone _____

Optometrist/Practice _____ Phone _____

Specialist/Type _____ Phone _____

Specialist/Type _____ Phone _____

Specialist/Type _____ Phone _____

Specialist/Type _____ Phone _____

We will utilize a screen share to review your analysis. Please mark ALL devices you have available:

☐ PC/Laptop ☐ Mac ☐ iPad ☐ iPhone ☐ Android ☐ None

Return form to: Jenell Sobas, Key2Medicare Insurance

Mail: 10268 W. Centennial Rd, Suite 200K, Littleton, CO 80127

Email: forms@key2medicare.com

Phone: 303-484-1763

7/2025

Disclaimer: Sharing this information with us is strictly voluntary. The information is used to create a more accurate analysis based on your specific situation.