

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 \_\_\_\_\_ Zip \_\_\_\_\_

Dentist/Practice \_\_\_\_\_ Phone \_\_\_\_\_ Zip \_\_\_\_\_

Optometrist/Practice \_\_\_\_\_ Phone \_\_\_\_\_ Zip \_\_\_\_\_

Specialist/Type \_\_\_\_\_ Phone \_\_\_\_\_ Zip \_\_\_\_\_

**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

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