My Plan Recap (MAPD)

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agent Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My agent’s contact number is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Base Plan Information:

My plan coverage is requested to begin on the effective date: \_\_\_\_\_\_\_\_\_\_\_

My Scope of Appointment was signed on this date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My plan type is (circle one):

**HMO** **HMO-POS** **PPO** **SNP** **PFFS Other:** \_\_\_\_\_\_\_\_\_

My carrier is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My plan’s star rating is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I live in my plan’s service area (County, State):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Premium Information:

My plan’s projected costs are $\_\_\_\_\_\_\_

This is scheduled to be withdrawn from my (**Checking** / **Social Security**) account on the \_\_\_\_\_\_\_\_ day of each month, starting in the month of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

When I pay my premium, I will pay (circle one):

**Monthly** **Quarterly** **Annually**

Provider/Pharmacy Information:

|  |  |  |  |
| --- | --- | --- | --- |
| Provider Name | Provider Type (Primary/Specialist) | In Network (Yes/No) | Requires Referral (Yes/No) |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

My pharmacy is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

With the plan I selected, my pharmacy is:

**Preferred** **In Network** **Out of Network**

Additional plans I have discussed with my agent:

* Dental/Vision/Hearing Insurance Accept / Decline
* Cancer/Heart Attack/Stroke Insurance Accept / Decline
* Hospital Insurance Accept / Decline
* Home Health Care Insurance Accept / Decline
* Final Expense Insurance Accept / Decline
* Skilled Nursing Facility Insurance Accept / Decline

Acknowledgement:

I know if I have a plan with a service area and I move out of the area, I will need to choose a new plan.

I have received my plan’s Summary of Benefits.

I know I must remain enrolled in Medicare Part A and Part B in order to keep this plan, and I will continue to pay my Part B premium. If I owe a Part B Late Enrollment Penalty or Income Adjusted Premium, I will need to add it to my premium each month.

I acknowledge that the above is true and accurate. If I have any issues or questions, I agree to call my agent at the previously listed number.

Client Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agent Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_