My Plan Recap (Medigap / PDP)

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 plan type is (circle one):

**A B C D F G K L M N**

My carrier(s) are: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Premium Information:

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

This is scheduled to be withdrawn from my Checking account on the \_\_\_\_\_\_\_\_ day of each month, starting in the month of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

My Prescription Drug 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This is scheduled to be withdrawn from my (**Checking** / **Social** **Security**) account on the \_\_\_\_\_\_\_\_ day of each month, starting in the month of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.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 I must remain enrolled in Medicare Part A and Part B 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_