MY MEDIGAP/PDP RECAP

AGENCY NAME
AGENT NAME
LICENSED SALES AGENT
(555) 555-5555 | agent@email.com
555 Agent Dr. | Columbia, MO 65201

Client Name: _____

Medicare Supplement

My Medigap plan coverage is requested to begin on the effective date of:

_____

My Prescription Drug Plan coverage is requested to begin on the effective date of: _____

My plan type is (circle one):

A B C D F G K L M N

My carrier for Medigap is: _____

My carrier for PDP is: _____

Premium Information

My Medigap plan's projected costs in _____ (year).

Premium $ _____

Copays $ _____

My prescription drug plan's projected costs in _____ (year).

Premium $ _____

Copays $ _____

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

Monthly **Quarterly** **Annually**

***By responding to letter, I understand a sales agent may contact me by telephone, email, or mail to discuss Medicare Advantage and Prescription Drug plans, and Medicare Supplement Insurance Plans. **We do not offer every plan available in your area. Currently we represent organizations which offer products in your area. Please contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program to get information on all of your options. **Not affiliated with or endorsed by any government agency.*

Provider/Pharmacy Information

Provider Name	Provider Type (Primary/Specialist)	Standard (Yes/No)	Requires Referral (Yes/No)

My pharmacy is: _____

With the plan I selected, my pharmacy is (circle one):

Preferred **Standard** **Out of Network**

Additional plans discussed with my agent (circle whether accepted or declined):

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** _____

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