2019 MEDICARE QUESTIONNAIRE

Our Medicare Questionnaire is voluntary and helps us prepare for our meeting with you. Please let us know about your doctors, medications and plan usage. Once complete, you can send this to our office.

CONTACT INFORMATION

Full Name ____________________

Address ____________________

City: ____________ Zip Code: ____________

Phone: ____________________

Email: ____________________

Date of Birth: ____________________

Medicare Claim#: ____________________

Effective Date (A) ____________ **Effective Date (B)** ____________

Current Clients: Please update only if your information has changed since last year.

PRIMARY DOCTOR — Who is currently treating you?

Physician Name: ____________________

Clinic Name: ____________________

Phone #: ____________________

Address: ____________________

City / Zip Code: ____________________

***** Please list all medications on the back side of this form *****

PLAN CHANGES — *What plan options will you need?*

• Need Vision Insurance?	YES	NO	MAYBE
• Need Dental Insurance?	YES	NO	MAYBE
• Need Chiropractic Insurance?	YES	NO	MAYBE
• Need Health Club Membership?	YES	NO	MAYBE
• Can you afford the current premium?	YES	NO	MAYBE
• Are you planning to travel (Snowbird)?	YES	NO	MAYBE
• Are you a Veteran? Do you have Tri-care?	YES	NO	MAYBE

ADDITIONAL TOPICS — What information would you like?

☐ **Planning** ☐ **Fixed Annuties** ☐ **Investments** ☐ **Long-Term Care** ☐ **Final Expense**

Signature: ____________________

I grant permission for Corbin Lindsey and Birdseye Financial to contact me between to discuss Medicare options available to me, which include: HMO, PPO, PDP, PFFS and Supplement plans. In addition, by signing above, you are allowing a licensed insurance agent to contact you by telephone, email or mail and provide additional information about Medicare and non-Medicare related products until December 31, 2020. You may cancel this agreement anytime in writing. You are not required to complete this form and have done so at your discretion.

Please send the completed form to our office

Office: (360) 722-7889

Fax #: (425) 412-6865

1402 7th Street, STE B

Marysville, WA 98270

info@birdseyefinancial.com

What Medicare Coverage do you have now?

	Advantage Plan PPO / HMO / HMO-POS	Medicare Supplement	Part D (stand-alone) Prescription Drug Plan
Insurance Company:	________________	________________	________________
Insurance Plan Name:	________________	Plan F or G	________________
Premium Payment:	$________________	$________________	$________________

Medication Name	Dosage	Frequency	(Office Notes)

***** If you need more space, please attach a separate piece of paper to this sheet with additional information.**

ADDITIONAL DOCTORS or SPECIALIST

Physician Name: ________________
Clinic Name: ________________
Phone #: ________________
Address: ________________
City / Zip Code: ________________

Physician Name: ________________
Clinic Name: ________________
Phone #: ________________
Address: ________________
City / Zip Code: ________________

SPECIAL NOTES

Office: (360) 722-7889
Fax #: (425) 412-6865
1402 7th Street, STE B
Marysville, WA 98270
info@birdseyefinancial.com