Pre-Enrollment Form

MEDICARE OPEN ENROLLMENT October 15th to December 7th

Return Completed Form To: evette.woods@atrc.net or Fax to 334-682-4045
NO LATER than December 3, 2021

Exact Name on Medicare Card	Date of Birth	Birth Place (city, state, country)

Spouse/Former Spouse Name: Spouse/Former Spouse Date of Birth:

Your Social Security #: Spouse/Former Spouse SS #:

Are You a Veteran? ☐Yes ☐No Spouse/Former Spouse a Veteran? ☐Yes ☐No

Physical Address: Email: County:

Mailing Address: Phone: ( ) or ( )

Number of other dependents: Marital Status: Reside with a spouse? ☐Yes ☐No

Other contact name/phone: I last contacted SHIP in ________ (year)

Currently enrolled in: Original Medicare☐ or Name of Managed Care Plan ________________________________

Name of any Medicare Supplement ____________________ Plan Letter ____ Monthly premium ____________

Name of other current health insurance: ________________________ ☐Retiree plan ☐Active employee plan

☐Veterans Administration ☐Federal retiree ☐State or public education retiree ☐TRICARE for Life

Medicare Card Information

Medicare Card Number:
SEE EXAMPLE ON THE BACK

Part A effective Date:

Part B effective Date:

Zip code where I receive Social Security mail:

Do you need a new Medicare Card? ☐Yes ☐No

MyMedicare.gov Account Info

☐ I set up my own MyMedicare.gov Account

User ID: Password:
Security Question/Answer:

Zip code of any representative payee:

Do you prefer not to provide this information?

Income/Subsidy Information/POA

My own gross monthly income: $____________

Spouse gross monthly income: $____________

Is any of this income wages, salary, or self-employment? ☐Yes ☐No

Are you currently receiving? ☐Extra Help/LIS

☐SSI ☐Medicaid Waiver ☐QMB ☐SLMB/QI

Pharmacy Information

Do you have a power of attorney? ☐Yes ☐No

Preferred Pharmacy?____________________________

Alternate Pharmacy?____________________________

Do you use Mail Order? ☐Yes ☐No

Prescriptions not covered by current plan: ☐ None

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY

____

MEDICARE CLAIM NUMBER

____

IS ENTITLE TO		EFFECTIVE DATE
HOSPITAL	(PART A)	____________________
MEDICAL	(PART B)	____________________

Please list each of your prescriptions in the two columns below.

For each, list the **name exactly as it appears on the container**, **the strength,** mg, mcg, ml, or other strength, **the form**, such as TAB, CAP, cream, ointment, liquid, etc., and **the amount of each fill**, such as 30/mo, 90/3 mo, 1 tube/mo, 2 vials/3 mo, 1 bottle/3 mo, 5 boxes of 3 pens/3 mo, etc.
Remember to include injections, breathing treatments, ointments, creams, etc.

Prescriptions	Prescriptions

Contact Preferences:

FOR OFFICE USE ONLY:

Contact Date and Time:____**Counselor Name:** ________________________

Sent Comps, Materials, Mail ☐ **Emailed** ☐ **Fax Date**____