



Medicare Consultation Preparation Form

Force Advisors • Confidential client information

Today's Date

Please complete the questions on this form with as much detail and accuracy as possible. If anything is unclear, leave it blank and we will go over it together during your consultation.

1. YOUR INFORMATION

Full Name

Date of Birth

Home Address (physical address – no PO Box)

City

State

ZIP

Do you have a separate mailing address?

☐ Yes

☐ No

Mailing Address (PO Box allowed)

Personal Email

Preferred Contact Phone

How did you hear about us?

2. CURRENT HEALTH COVERAGE

Do you currently have health insurance?

☐ Yes

☐ No

Current health insurance type

☐ Employer group

☐ Individual / Marketplace

☐ COBRA

☐ Retiree plan

☐ Medicaid

☐ Medicare

☐ VA / TRICARE

☐ None

Other:

Employer Providing Your Current Health Insurance

Current Insurance Company

Health Insurance ID Number

Date New Medicare Coverage Is Needed

Your basic understanding of Medicare

☐ None

☐ A little

☐ Moderate

☐ Strong

3. YOUR MEDICARE STATUS

Helpful: our 8-minute “ABCs of Medicare” video explains the basics and your supplemental insurance choices.

Watch: <https://vimeo.com/589930490>

Are you enrolled in Medicare?

☐ Yes

☐ No

Tip: The Medicare ID (e.g. 1EG4-TE5-MK72) and Part A / Part B start dates are printed on your red, white & blue Medicare card.

Medicare ID Number (if enrolled)

Part A Effective Date

Part B Effective Date

4. PRESCRIPTIONS

Do you take prescription medications currently?

☐ Yes

☐ No

Tell us about your current prescriptions

	Drug Name / Brand?	Dosage (cap/tab)	Monthly Quantity	Refill Frequency
Rx 1				
Rx 2				
Rx 3				
Rx 4				
Rx 5				
Rx 6				
Rx 7				
Rx 8				
Rx 9				
Rx 10				

Preferred Retail Pharmacy Name

Is a mail-order pharmacy option important to you?

☐ Yes

☐ No

5. DOCTORS & PROVIDERS

Do you have a Primary Care Doctor?

☐ Yes

☐ No

Name of Primary Care Doctor

	First Name	Last Name	City/Town
PCP			

Do you see other specialist doctors on a regular basis? ☐ Yes ☐ No

Names of current specialist doctors

	First Name	Last Name	Specialty	City/Town
Specialist 1				
Specialist 2				
Specialist 3				
Specialist 4				
Specialist 5				
Specialist 6				
Specialist 7				
Specialist 8				
Specialist 9				
Specialist 10				

Do you have a dentist? ☐ Yes ☐ No

Dental providers

	First Name	Last Name	Type	City/Town
Dental 1				
Dental 2				

Notes or important additional providers (hospitals, rehab facilities, etc.)

6. INCOME

We only ask about income to help estimate your government costs for Medicare. Higher-income earners can pay more for Medicare (IRMAA) than lower-income individuals.

Modified Adjusted Gross Income (MAGI) from 2 years ago

Will your income be significantly reduced this year? ☐ Yes ☐ No

Do you file taxes individually or jointly with a spouse?

☐ Individually

☐ Jointly

7. SPOUSE INFORMATION

Skip this section if not applicable

Will your spouse need Medicare coverage?

☐ Yes

☐ No

Spouse's Name

Spouse's Date of Birth

Is your spouse's residence the same as yours? (for plan options)

☐ Yes

☐ No

Spouse's Address (if different)

Is your spouse covered under your health insurance (or vice versa)?

☐ Yes

☐ No

Spouse's health insurance type

☐ Employer group

☐ Individual / Marketplace

☐ COBRA

☐ Retiree plan

☐ Medicaid

☐ Medicare

☐ VA / TRICARE

☐ None

Other:

Employer Providing Spouse's Health Insurance

Spouse's Health Insurance Company

Spouse's Health Insurance ID Number

Is your spouse enrolled in Medicare?

☐ Yes

☐ No

Tip: The Medicare ID (e.g. 1EG4-TE5-MK72) and Part A / Part B start dates are printed on your spouse's red, white & blue Medicare card.

Spouse's Medicare ID Number

Part A Effective Date

Part B Effective Date

Does your spouse take prescription medications?

☐ Yes

☐ No

Your spouse's current prescriptions

	Drug Name / Brand?	Dosage (cap/tab)	Monthly Quantity	Refill Frequency
Rx 1				
Rx 2				
Rx 3				
Rx 4				

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Your spouse's current prescriptions (continued)

	Drug Name / Brand?	Dosage (cap/tab)	Monthly Quantity	Refill Frequency
Rx 5				
Rx 6				
Rx 7				
Rx 8				
Rx 9				
Rx 10				

Spouse's Preferred Retail Pharmacy

Is a mail-order pharmacy important to your spouse? ☐ Yes ☐ No

Does your spouse have a Primary Care Doctor? ☐ Yes ☐ No

Spouse's Primary Care Doctor

	First Name	Last Name	City/Town
PCP			

Does your spouse see specialist doctors on a regular basis? ☐ Yes ☐ No

Spouse's current specialist doctors

	First Name	Last Name	Specialty	City/Town
Specialist 1				
Specialist 2				
Specialist 3				
Specialist 4				
Specialist 5				
Specialist 6				
Specialist 7				
Specialist 8				
Specialist 9				
Specialist 10				

Does your spouse have a dentist? ☐ Yes ☐ No

Spouse's dental providers

	First Name	Last Name	Type	City/Town
Dental 1				
Dental 2				

Spouse's notes or important additional providers (hospitals, rehab facilities, etc.)

8. YOUR PREFERENCES

Are you a US Military Veteran?

☐ Yes

☐ No

What's most important to you? (check all that apply)

☐ Low monthly premium

☐ Low out-of-pocket costs

☐ Keeping my current doctors

☐ Freedom to see any doctor

☐ Prescription drug coverage

☐ Dental / vision / hearing

☐ Coverage when traveling

☐ Predictable costs

Other:

Do you know what type of Medicare plan you are interested in?

☐ Medicare Supplement (Medigap)

☐ Medicare Advantage

☐ Part D drug plan only

☐ Not sure yet

Insurance companies you may prefer working with (check all that apply)

☐ AARP / UnitedHealthcare

☐ Aetna

☐ Blue Cross Blue Shield

☐ Cigna

☐ Harvard Pilgrim

☐ Humana

☐ Mutual of Omaha

☐ Tufts Health Plan

☐ Wellcare

☐ No preference

Other:

Anything else you'd like us to know before your consultation?