INDIVIDUAL & MEDICARE PROSPECT FORM

Individual(s) in need of coverage:

Name of client:		Tobacco Use? ◯Yes ◯No	DOB:
Name of spouse:		Tobacco Use? ◯Yes ◯No	DOB:
Dependent:		Tobacco Use? ◯Yes ◯No	DOB:
Dependent:		Tobacco Use? ◯Yes ◯No	DOB:
Dependent:		Tobacco Use? ◯Yes ◯No	DOB:
Home Address:	County: Phone:	Email:	

Describe the coverage you currently have (if applicable):

Company/Plan name:	
Medications you take:	
Facilities you use:	
Names of your Physicians:	

When does/did your current coverage end?:

When do you need new coverage to begin?:

Preferences for new coverage:

Category of coverage:	◯Medicare ◯Individual/Family
Network type:	◯PPO ◯HMO ◯EPO ◯No Preference
Carrier-network preference:	◯Highmark ◯UPMC ◯No Preference ◯Other:
Additional coverage/needs:	☐Dental ☐ Vision ☐ Auto ☐ Home/Renters ☐ Financial Planning ☐ International Coverage ☐ Other:

Why do you need coverage?:

◯ Research during Annual Open Enrollment Period ◯ 26-year-old age-in ◯ Retirement ◯ Medicare age-in

◯ Involuntary loss of coverage: Loss of job (compare to COBRA)

◯ Other: