Medicare and Prescription Drug Check Up

No ONE plan fits all. Allow me to find the best plan to fit your individual needs.

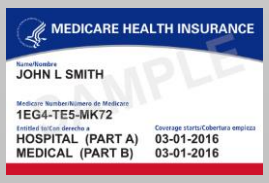
Please fill out this entire form, sign and date and mail to:

Schneider Senior Solutions - 120 Mill St, Gahanna OH 43230

Once received, we will contact you for your FREE personalized plan review.
OR call Amanda Schneider at 614-571-6922 to schedule your free personalized review.

** Appointments can be handled over the phone, online, or on a face-to-face basis by appointment only.

We need the four following items for your appointment.



Your Medicare Card

Your Checking/Savings Info

This Completed Form

Your Insurance Card(s)

Name:_____ Date of Birth:_____

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

County:_____ Gender: ☐ Male ☐ Female

Best Contact Number(s):_____

Why are you shopping?_____

What plan do you currently have?_____

Do you travel? ☐ Yes ☐ No Do you travel Internationally? ☐ Yes ☐ No

How long do you travel at a time?_____

Are you a Veteran? ☐ Yes ☐ No

Are you offered any type of Retirement Plan? (Ex. STRS- State Teachers Retirement System, OPERS- Ohio Public Employees Retirement System, PFRO- Police & Fire Retirees of Ohio):_____

Are you having trouble paying for your medications? ☐ Yes ☐ No

Are you on Medicaid? ☐ Yes ☐ No

What benefits are important to you? ☐ Dental ☐ Vision ☐ Hearing
☐ Groceries ☐ Indemnity Plans ☐ Life Insurance

Primary Care/Doctor Info

Who is your Primary Care Doctor? _____

Primary Care ID #:_____

What Hospital Would you use in Emergency?_____

Fill In Below or Check Up Form (Separate Document):

Name Of Doctor	Specialty	Address
Ex. Dr. Julie Smith	Orthopedic	1234 Clark St NW Cleveland OH 44140

Prescription & Pharmacy Info

Current Pharmacy:_____

Prescription Drug	Dosage	Form	Quantity	How Often is it Filled?
Ex. Lisinopril	20 MG	Tablet	90	Every 3 months

Do you use a mail order Pharmacy? ☐ Yes ☐ No If yes, which one?_____

Do you want more information on the Insulin Savings Program? ☐ Yes ☐ No

Authorization

I have voluntarily provided the information on this three-page form to to review my options for a health plan. I am pursuing consultation and advice for a Medicare plan that will best serve my needs. I agree to receive my personal NO COST, no obligation recommendation and I further authorize _____ to contact me by phone or mail, if needed. This information provided to _____

on this form is NOT to be used for any other purpose than my Medicare plan selection. I understand I am not bound to accept any recommendation. By signing below, I am authorizing a licensed agent named _____ to contact me regarding my Medicare options.

Signature:_____ Date:_____