**Last Name:**_____ Date:_____Medicare Plan quote sheet

How did you locate us or who referred you? _____

**Initial Contact Method** _____

**Name & Occupation** _____ /

**Date of Birth / Height & Weight** _____ /

Home Phone #:_____Email:_____

Cell Phone #:_____

**Are you getting Social Security benefits** If yes, date you started receiving the benefit: _____

If no, date when you plan on starting the benefit: _____

Tobacco use Yes No

Where do you Live? City: Zip Code: County:

Current health coverage (circle) Yes No If yes, list name of insurance company below

What type of coverage is it? (circle) Group Individual

**Requested effective date:** _____

Medicare Part A effective date _____

Medicare Part B effective date _____

**List any recent health issues or surguries**

**if not applying during open enrollment**

1 _____

2 _____

3 _____

Please provide a copy of your Medicare Card

**Fax to:** 972-767-1432 or email: jeanette@bowmanbenefits.com