



Medicare Insurance Questionnaire

Name: _____ Gender: _____ DOB: _____
Spouse: _____ Gender: _____ DOB: _____
Address: _____ County: _____
City: _____ State: _____ Zip: _____
Phone: _____ Best time to call: _____

****AGENT USE ONLY****

Referred by: _____
Have you attended a Medicare seminar? Location? _____

Current Coverage? Yes No Employer Individual

If individual, do you have a marketplace plan with subsidy? (APTC)? _____
If group, name of Employer: _____

Is the employer plan an ICHRA? Yes No

If Y, what is your employer ICHRA contribution? _____

Number of Employees: Under 20 20 or more

Creditable Rx Coverage? Yes No (if unsure, contact HR)

Does your spouse have access to their group coverage? Yes No

Planning to retire or leave group coverage? Yes No Date? _____

Medicare A and/or B? Yes No

Effective date: Part A: _____ Part B: _____

Request follow up? _____

Notes: _____

