

Please contact me about Medicare and Health plans.

Adding your contact details on this form is entirely voluntary.

I am inviting your permission to follow up regarding:

- | | |
|---|--|
| ☐ Medicare Advantage plans | ☐ Dental & Vision plans |
| ☐ Medicare Part 'D' Drug plans | ☐ Medicare Supplements |
| ☐ Hospital and Accident plans | ☐ Travel Medical |

This permission to contact is of limited duration, we aim to contact you at your convenience – we will not reach out if we have not connected within 90 days.

Preferred method of contact ☐ Call ☐ Text ☐ Email

Preferred time of contact ☐ Daytime ☐ Evening ☐ Either

First Name _____ Last Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Phone _____ Email _____

Currently Medicare eligible: ☐ Yes ☐ No

If no when will you be eligible: _____

If I do not have a current enrollment period before October 15th, we will also follow up with you between October 1st and December 7th during the Annual Election Period.

By providing my email or telephone number, I agree to allow a licensed advisor to contact me regarding Medicare health plans and health insurance plans, products, services and/ or educational information related to health insurance.

Client Signature _____

Date _____

Advisor Signature _____

Date _____