Questionnaire

For people who plan to enroll in Medicare in the near future

Please send us your completed questionnaire by e-mail, FAX, or U. S. Mail:

E-mail: doverhealthcareplanning@gmail.com

Fax: (562) 498-7348

U. S. Mail: 461 Kakkis Drive, #102, Long Beach, CA 90803.

Or if you'd like to complete the questionnaire over the phone, please send us an e-mail to suggest a time that is good for you, or call our office toll-free at (877) 236-7710.

Your Name and Mailing Address (including home zip code):

_____

_____

_____

The county you live in: _____

Your e-mail address: _____

If you wish to have a password for your evaluation, please write it on the line below:

_____

A: Enrollment and eligibility questions

1. What is your date of birth? _____ _____ _____
   Month *Day* *Year*

2. Are you already enrolled in Part A of Medicare? ☐ Yes ☐ No

3. When will you begin your Medicare (A+B) coverage? _____ _____ _____
   Month *Day* *Year*

4. Are you currently receiving Social Security payments? ☐ Yes ☐ No

5. Are you making contributions to a Health Savings Account? ☐ Yes ☐ No

Section A questions are continued on the next page

For Office Use
Client Number:
_____

A: Enrollment and eligibility questions *(continued)*

6. Please check the boxes that apply to you.

☐ Neither I nor my spouse currently works for a company with 20 or more employees.

☐ I will not have access to retiree health coverage to supplement Medicare.
(Note: if you do have employer retiree health coverage you probably do not need an evaluation).

B: The names of your doctors

We will look for plan networks that include all of your physicians

Physician's Last Name	*First Name*	*Specialty*	*Office Zip Code*

C: Your prescription drugs

1. What is the name of the local pharmacy you prefer to use?
   _____

2. Check ONE of the following boxes:

☐ I do not take any prescription drugs (if you check this box, you can skip to Section D)

☐ I take prescription drugs and get monthly refills

☐ I take prescription drugs and get mail order (or 90-day) refills.

C: Your prescription drugs *(continued)*

List the prescription drugs that you take so that we can look for the lowest-cost plans for your drugs.

Example of Filled-in Rx Form

Name of Rx Drug (including suffixes)	*Dosage*	*How Often Do You You Take This Drug?*
Topol XL	50 mg	Two times a day
Fosamax Plus D	70 mg	Once a week
Advair Diskus	250/50 mcg	One inhalation, two

List the Rx drugs you take, the dosages, and how often you take each drug.

	Name of Drug	*Dosage*	*How Often Do You Take?*
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____
11.	_____	_____	_____
12.	_____	_____	_____

If you need to list additional drugs, please attach another page

D: Do you prefer a certain type of coverage?

Unless you have an employer plan to supplement Medicare, you will need either a Medigap policy or a Medicare Advantage plan. Medigap policies don't have networks and are typically more expensive. Advantage plans are managed care plans like HMO's and PPO's. Do you prefer one or the other or do you wish to see comparisons of both of these types of coverage?

☐ I'd like to see comparisons of both of these types of coverage

☐ I'm only interested in Medigap policies ☐ I'm only interested in Advantage plans

E: Engagement terms

The cost of an evaluation for new enrollees is $200 (billed at completion). Evaluations rely on information from Medicare and state insurance departments. Dover Healthcare Planning, LLC, believes this information to be accurate but is not responsible for its accuracy.

Please initial here to indicate that you agree to the engagement terms: _____