Time for your Prescription Drug & Medicare Annual Review

Medicare Open Enrollment Begins
October 15th

PLEASE COMPLETE ANNUAL REVIEW FORM

FIRST NAME _____ LAST NAME _____

ADDRESS _____

CITY _____ COUNTY _____

STATE _____ ZIP _____ DATE OF BIRTH ___/___/___

HOME PHONE _____ CELL PHONE _____

PREFERRED PHARMACY _____

Have Medicare Part A	yes ☐ no ☐	Have Medicare Supplement	yes ☐ no ☐
Have Medicare Part B	yes ☐ no ☐	Have Medicare Advantage Plan	yes ☐ no ☐
Have a Prescription Drug Plan	yes ☐ no ☐	If yes, what insurance company? _____	

CLIENT SIGNATURE _____ DATE ___/___/___

*The information I provided above is accurate and to the best of my knowledge correct. I hereby hold harmless David A. Crotts & associates Inc. for any misrepresented information. In addition, I also granted permission to David a. Crotts & Associates Inc. to contact me about my insurance and or other insurance related matters.

David A. Crotts & Associates Inc.
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AUTO • HOME • BUSINESS

PLEASE LIST PRESCRIPTION DRUGS ON THE BACK

PRESCRIPTION DRUG LIST

(Please list all medications as listed on Rx Bottle)

Medication Name	Dosage	Frequency

Notes:

_____

_____

_____

_____

_____

AGENT USE ONLY

Medicare Web ID: _____

Medicare Date: _____

Medicare Zip Code: _____

Agent: _____ Date: _____