

SHIIP Client Information Form

Please provide the following information for our records.

What is your name on your Medicare card and address on record with Medicare?

What is your Medicare effective date(s)? Part AMonth Day Year Part BMonth Day Year Part BMonth Day Year PART B D-ART B D3-03-2016 Representative Information (Son, Daughter, Friend or POA) Representative's Name Rep Address City State Zip Code Phone Email Address Client Demographics	First Name	M.I.	Last Name		Jr/Sr/I/II
City:	Client Address:				
Email Address What is your Medicare Claim Number on your Medicare card? What is your Medicare effective date(s)? Part A-Month Day Year Part B-Month Day Mellows Part B-Month Day Part B-Month Da			-		p Code:
What is your Medicare Claim Number on your Medicare card? What is your Medicare effective date(s)? Part AMonth Day Year Part BMonth Day Year Part BMonth City State Zip Code Phone Email Address Clity State State Client Demographics Date of Birth Primary Language English Other Is your income above or below the following amounts: Above Individual\$19,380/yr (\$1,615/mo) or Couple\$26,100/yr (\$2,175/mo) Are assets above or below the following amounts: Above Below Individual\$14,610 or Couple\$29,160 On Medicare Due to a Disability (under age 65): Yes No SHIIP Use Only: Premium Payment SSA Direct Bill Contact Person: Phone				e Phone	_
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City State Zip Code Phone Email Address Client Demographics Date of Birth / Gender: M F Primary Language English Other Is your income above or below the following amounts: Above Below Individual\$19,380/yr (\$1,615/mo) or Couple\$26,100/yr (\$2,175/mo) Are assets above or below the following amounts: Above Below Individual\$14,610 or Couple\$29,160 On Medicare Due to a Disability (under age 65): Yes No SHIIP Use Only: Premium Payment SSA Direct Bill Contact Person: Phone	Representative Inform	ation (Son, I)aughter, Frie	end or POA)	
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SHIIP Use Only: Premium Payment SSA Direct Bill Contact Person: Phone		•	_	Above	Below
Contact Person: Phone	On Medicare Due to a D	isability (unde	er age 65):	Yes	No
	SHIIP Use Only: Premium	n Payment SSA	Direct Bill		
	Contact Person:			Phone	

Hispanic, Latino, or Spanish Origin White, Not of Hispanic Origin Black, African-American		American Indian or Alaska NativeAsianNative Hawaiian or Other Pacific IslanderNot Collected	
How did you hear about Si	HIIP?		
Agency (e.g. AAA) Congressional Office DHS-State Medicai Friend/Relative Health/Drug Plan Insurance agent/cor Mailings/Brochures Media (newspaper,	ce d Agency npany /Posters/Newsletters	Medical Provider Medicare (e.g. 800#, pub, mailing Pharmacy Presentations/Fairs Prior Contact SHIIP Website SSA Other Not Collected	
Complete this inform	ation only if you need	a Medicare Part D Comparison	
What is your current drug	g coverage? Check any the	at apply.	
Medicare Part D Plan Name	nn		
Medicare Advantag Plan Name	e Plan		
TRICARE for Life VA benefits None	Employer/F Federal Em Other	Retiree plan ployee Health Benefit Plan	
How would you like to go	et your Medicare drug ben	efits? Please provide a comparison of	
(check one): Medicare drug plans	only Medicare A	dvantage Plans only Both	
Medicaid (Title 19 - M Help paying your Me Extra Help with your Pay \$1.25 for generic	dicare Part B premium (QM Medicare drug costs s and \$3.80 for brand name s and \$8.50 for brand name	lically Needy Spend-down, Nursing Home) IB, SLMB, QI) drugs	
Final Property as you pro			
Name of Pharmacy	Address and City	Phone Number	
Name of Pharmacy	Address and City	Phone Number	

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