Medicare Part D Personal Information Worksheet

Use this worksheet to help gather all the information you need to choose a Medicare drug plan that meets your needs. Please fill out as much of the information on this worksheet as possible.

Complete the following personal information

Currently I have a: ☐ Medicare Part D Drug Plan ☐ Medicare Advantage Health Plan ☐ Neither

Name: _____ Date of Birth: _____-_____-_____

Address: _____ County: _____

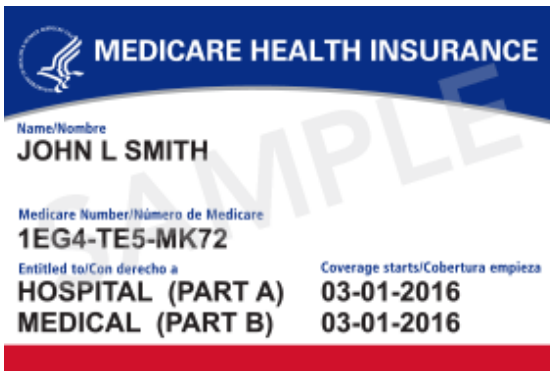
City: _____ State: _____ Zip Code: _____

Telephone Number: (_____) _____-_____

Medicare Claim Number: _____

Part A Effective Date: _____-_____-_____

Part B Effective Date: _____-_____-_____



☐ My income and assets are below the following guidelines:
Individual: Monthly Gross Income: $1,538 Assets: $14,100
Married Couple: Monthly Gross Income: $2,078 Assets: $28,150

List the prescription drugs you are currently taking on the back of this sheet

If you have a current list of your prescriptions, you **DO NOT** need to recopy them; simply include your list with this sheet.

List the pharmacy you prefer to use

Pharmacy Name: _____ Location: _____

Pharmacy Name: _____ Location: _____

Read and sign below

By signing below, I acknowledge that I am making my enrollment, or non-enrollment, decision freely and voluntarily. While I may receive information from a counselor with the Nebraska Senior Health Insurance Information Program (SHIIP), the final decision will be made of my own free will and choice. I understand that the counselor who assists me may be a volunteer and will only provide me with information to assist me in my decision. I further understand that drug pricing data available on the www.medicare.gov Plan Finder is only an estimate and subject to change. I hereby release any and all liability that may possibly be attributable to the volunteer counselor and agree not to pursue any legal action against the counselor and/or SHIIP for actions taken in their capacity as a counselor.

Signature: _____ Date: _____

List the prescription drugs you are currently taking on the back of this sheet

If you have a current list of your prescriptions, you **DO NOT** need to recopy them; simply include your list with this sheet.

Drug Name	Dosage	Taken how often

For SHIIP Volunteer Use:

Volunteer Name: _____ **Date**:_____

Drug List ID: _____ **Drug List Password Date:** _____

Did You Enroll in Part D Plan? Yes No **Enrollment Confirmation Number:** _____

Old Plan Yearly Cost: $_____ - **New Plan Yearly Cost:** $_____ = **Savings** $_____

Client Contact Completed: ☐ Online ☐ Paper **Follow Up Required:** ☐ Yes ☐ No