

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 Part B yes no
 Have a Prescription Drug Plan yes no

Have Medicare Supplement yes no
 Have Medicare Advantage 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. Crofts & associates Inc. for any misrepresented information. In addition, I also granted permission to David a. Crofts & Associates Inc. to contact me about my insurance and or other insurance related matters.



David A. Crofts & 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: _____