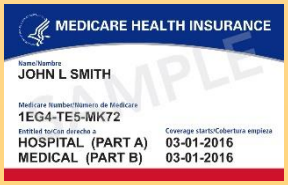
Medicare and Prescription Drug Check Up Form

Allow TLC Insurance Group to compare all your plan options for you!
Questions? TLC Retiree Service Center: 1-800-719-3751

Step 1: Please fill out this entire form and bring it with you to your scheduled meeting.

Step 2: Or mail this completed form in the postage paid envelope provided and once received, we will contact you to schedule your free personalized review.

Step 3: What do I need to have ready for my appointment? The four important items below:



Medicare Card

Current Insurance Card

This Completed Form

Checking/Savings Info
(In Case It Is Needed)

Your Name _____ Date of Birth _____

Mailing Address _____ Gender _____

City _____ State _____ Zip Code _____ County _____

Home Phone _____ Cell Phone _____

What current medical plan do you have (as listed on your insurance ID card or bring it with you) _____

Do you travel? YES or NO If yes, for how long? _____

Please list your preferred physicians, including full name, specialty, and office address. (Please do not include dentists)

Primary Care/Family Doctor

Name (First & Last) _____

Office Address _____

Your Preferred Hospital _____ Hospital City _____

Please list any health conditions you may have _____

_____

PLEASE COMPLETE BOTH SIDES OF THIS FORM- THANK YOU CheckupNARVRE22

Specialists

Name (First & Last) _____ Specialty _____

Office Address _____

Name (First & Last) _____ Specialty _____

Office Address _____

Name (First & Last) _____ Specialty _____

Office Address _____

Prescriptions

Please list all of your current prescription medications as they are written on your medication bottles (list Generic name if used). List only medications prescribed by your doctor and do not include over the counter items. If you need additional space, please use a separate sheet of paper and have it available for your appointment along with the four pictured items listed on the front page. Please fill out completely to assist us in helping you.

Example: **Rx Name** – Lisinopril **Dosage**- 20 mg **How Often**- 2 X a day

Rx Name _____ Dosage _____ How Often _____

Rx Name _____ Dosage _____ How Often _____

Rx Name _____ Dosage _____ How Often _____

Rx Name _____ Dosage _____ How Often _____

Rx Name _____ Dosage _____ How Often _____

Rx Name _____ Dosage _____ How Often _____

Top 2 Pharmacies Used (1): _____ (2): _____

Do you use Mail Order Pharmacy: Yes ____Or No_____?

Authorization

I have voluntarily provided the health information on this sheet to TLC Insurance Group to aid in the choice of an individual/group health plan. I am pursuing their advice for a Medicare plan that will best serve my needs. I agree to receive my personal no cost, no obligation recommendation and I further authorize TLC Insurance Group to contact me by phone or mail, if needed. This information, provided to TLC Insurance Group on this form, is not to be used for any purpose other than for my Medicare health plan selection. I understand I am not bound to accept their recommendation. By signing below, I am authorizing a licensed agent from TLC to contact me regarding my healthcare needs.

Signature _____ Date _____

POA Signature (Only if applicable) _____ Date _____