TLC Insurance Group & Wealth

NARVRE

Medicare Health Plan and Prescription Drug Check Up Form

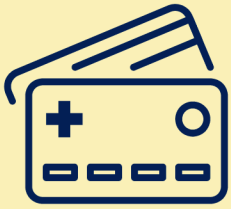
Step 1: Please complete this entire form, sign and date it, and mail to TLC Insurance Group using the enclosed postage-paid return envelope.

Once we receive your form, we'll contact you to schedule your free, personalized Medicare plan review. If you'd prefer, you can call us directly at **1-800-719-3751** to set up your review.

***By calling this number, you will be connected with a licensed insurance agent. Personalized reviews can be completed by phone or in person. In-person appointments are available by request, where available.*

Step 2: Please have these items ready for your appointment:

Medicare Card



Current Insurance Card(s)

This Completed Form

Banking Info.
(In case it is needed)

Note: If you are not mailing this form, please bring it with you to your appointment. It helps us provide the most accurate and personalized review.

Full Name: _____ Gender: ◯ Male ◯ Female
First & Last Name

Date of Birth: _____ Email: _____

Physical Address: _____
Street City State Zip Code County

Mailing Address: _____
(if different) *Street City State Zip Code*

Home Number: _____ Mobile Number: _____

Do you travel? ◯ Yes ◯ No If yes, for how long? _____

Do you receive Extra Help or Medicaid? ◯ Yes ◯ No Are you a veteran? ◯ Yes ◯ No

Preferred Providers

Primary Care Physician: _____
First & Last Name

Office Address: _____
Street City State Zip Code

Hospital: _____ Location: _____
City State

Dentist: _____ Location: _____
City State

Optometrist: _____ Location: _____
City State

Please complete both sides of this form. Thank you!

Specialist: _____ Specialty: _____
First & Last Name

Office Address: _____
Street *City* *State* *Zip Code*

Specialist: _____ Specialty: _____
First & Last Name

Office Address: _____
Street *City* *State* *Zip Code*

Specialist: _____ Specialty: _____
First & Last Name

Office Address: _____
Street *City* *State* *Zip Code*

Specialist: _____ Specialty: _____
First & Last Name

Office Address: _____
Street *City* *State* *Zip Code*

Prescriptions

Please list all your current prescription medications exactly as they appear on your medication bottles. Only list prescriptions written by your doctor. Do not include vitamins, supplements, or other over-the-counter items. If you need more space, you may attach an extra sheet of paper.

Note: *When listing a medication, be sure to include the form (tablet, capsule, vial, pen, tube) and the size (e.g., 10 mL vial).*

e.g., **Rx Name**: Metformin HCL **Dosage**: 500 MG **Form**: Tablet **Qty. Per Fill:** 180 **Fill Frequency:** 90 days

Rx Name	Dosage	Form	Qty. Per Fill	Fill Frequency

Preferred Retail Pharmacies: (1) _____ (2) _____

Do you use Mail Order Pharmacy: ◯ Yes ◯ No

Authorization

I am voluntarily providing the information on this form to help select an individual or group Medicare plan. I understand that I am seeking guidance and a personalized recommendation at no cost and with no obligation. I authorize TLC Insurance Group to contact me by phone, email, or mail if needed. The information I've provided will be used only to help identify the Medicare plan that best fits my needs. I also understand I am not required to accept any recommendation. By signing below, I give permission for a licensed agent to contact me regarding my healthcare coverage.

Signature: _____ Date: _____

POA Signature: _____ Date: _____
(If applicable)