Date: _____ **2023 AEP Personal Information Sheet (one per person)**

Agent Name: _____

Are you a current client? ☐ Yes ☐ No **If not, how did you hear about us?** _____

Name_____**DOB**_____**Phone**_____

Address_____**City**_____ **State**_____**Zip**_____

County_____ , USA **Email**_____ **Tobacco Use last 12 months?**_____

SECTION A: Fill out this section ONLY if you have a Medicare Supplement (Medigap) and Part D Drug Plan

Medicare Supplement Company Name_____ **Plan(F, G, etc.)**_____(on your Insurance Card)
(NOTE: Your Med Supp is not analyzed during AEP; you can apply to change plans anytime, subject to health underwriting questions)

Current Prescription Drug Plan Name_____(on your Insurance Card)

Are you considering changing to a Medicare Advantage Plan? ❒ **Yes** (Complete SECTIONS C and D below)
❒ **No** (Complete SECTION C below)

SECTION B: Fill out this section ONLY if you have a Medicare Advantage Plan

Medicare Advantage Plan Name _____(on your Insurance Card)

❒ **I've reviewed my Annual Notice of Change (ANOC) and wish to STAY on my current plan for 2023** (we do NOT need your medication list; you do NOT need to complete Sections A, C or D)

OR

❒ **I would like to change Medicare Advantage Plans for 2023** (Complete SECTIONS C and D below)
Please tell us why? _____Are you okay with changing doctors? ☐ **Yes** ☐ **No**

SECTION C: Prescription Medications (REQUIRED to complete your drug analysis)

❒ Mark here if you take NO medications ***OR*** ❒ My current medication list is attached (REQUIRED even if your medications have not changed)

Current Pharmacy or Mail Order name (VERY IMPORTANT) _____

SECTION D: Fill out this section ONLY if you want to change Medicare Advantage plans ***OR*** move from your Medicare Supplement (Medigap) to Medicare Advantage

Primary Care Dr. Name_____Phone_____

Specialist Name/Type_____Phone_____

Specialist Name/Type_____Phone_____

Optometrist/Practice Name_____Phone_____

Dentist/Practice Name_____Phone_____

❒ **Mark here if you do NOT have access to a computer and internet**

Return form to HealthCare Benefit Services
Mail: 6638 W. Ottawa Ave, Suite 120, Littleton, CO 80128
Fax: 720-287-7055, Email: info@HBSLTC.com (Email is not a secure form of communication)
Phone: 303-973-6636 or **800-295-5860**

Current Medication List – AEP 2023

REQUIRED for us to complete your drug analysis (even if no changes from last year)

Your Name:_____ **Date**:_____

Complete Drug Name from Bottle/Container	**Dosage / Container Size** See list below	**Form** See list below	**Quantity Per Refill**	**Refill Frequency** See list below	**Generic OK** (Y)es or (N)o	**Using GoodRx*** (Y)es or (N)o
EXAMPLES						
Metoprolol Succinate ER	50mg	Tab	90	Q	Y	N
Albuterol Sulfate HFA	90mcg/8.5g	Inhaler	1	M	Y	Y

FORM: Tab Cap Inhaler Drops Patch Injection Vial Lotion Cream Ointment Gel

DOSAGE/SIZE: Be sure to list BOTH dosage and container size for Inhalers, Drops, Lotions, Creams, Ointments and Gels

REFILL FREQUENCY: (M)onthly (Q)uarterly (SA)Semi-Annually (A)nnually (BM)Every 2 months

DO NOT list "AS NEEDED" – Complete Refill Frequency with one of the above options

*Answer (Y)es if using GoodRx or any other discount drug plan to fill medication

Return form to HealthCare Benefit Services
Mail: 6638 W. Ottawa Ave, Suite 120, Littleton, CO 80128
Fax: 720-287-7055, Email: info@HBSLTC.com (Email is not a secure form of communication.)
Phone: 303-973-6636 or **800-295-5860**