

Date: _____ **Personal Information Sheet (one per person)** Referred by: _____

Name _____ DOB _____ Phone _____

Address _____ City _____ State _____ Zip _____

County _____ Email _____ Tobacco Use last 12 months? _____

Marital Status: Married Single, Live Alone Single, Live With Someone

What health coverage do you currently have? (Mark box that applies):

Individual Employer Retiree Plan Name _____ Drug Coverage Included? _____

Medicare Advantage Plan Name _____ (on your Insurance Card)

Medicare Supplement Company Name _____ Plan(F, G, etc.) _____ (on your Insurance Card)

AND Plan Name of Current Prescription Drug Coverage _____ (on your Insurance Card)

Do you have Medicare?: Part A Part B Mark here if you have a MyMEDICARE.gov account set up

Veteran? (yes/no) _____ Interested in a Plan with Health Club Membership? (yes/no) _____

Current Pharmacy Name/Mail Order (very important) _____

Mark here if you take NO medications **OR** My current medication list is attached (form provided)

NOTE: Some plans have Doctor networks, we want to check to see if your docs accept various plans

Primary Care Doctor _____ Phone _____

Dentist/Practice _____ Phone _____

Optometrist/Practice _____ Phone _____

Specialist/Type _____ Phone _____

Specialist/Type _____ Phone _____

Specialist/Type _____ Phone _____

Specialist/Type _____ Phone _____

We will utilize a screen share to review your analysis. Please mark ALL devices you have available:

PC/Laptop Mac iPad iPhone Android None

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

9/19/2022

Disclaimer: Sharing this information with us is strictly voluntary. The information is used to create a more accurate analysis based on your specific situation.