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**?_____

Do you have an HSA (Health Savings Account)? yes/no _____

❒ **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 (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**

8/2/2023