Medicare Readiness Assessment

When you complete the form hit the send form button to send it to Elite Insurance

Send Form

Contact Information

First Name:_____ Last Name: _____Date of Birth: _____

Address:_____

City:_____State: _____ Zip:_____County:_____

Phone: _____ Email: _____

Spouse Information

First Name:_____ Last Name: _____Date of Birth: _____

Financial Information

Estimated Annual Household Income: _____ Retired: Yes ☐ No ☐ Retirement Date: _____

Receiving Social Security Disability Benefits: Yes ☐ No ☐ Start Date: _____

Insurance Information

Company Name: _____Premium: _____

PCP Copay: _____ Deductible: _____ Maximum: _____

Medicare #:_____ Part A Effective Date: _____ Part B Effective Date: _____

Health Savings Account: Yes ☐ No ☐ Creditable Drug Coverage: Yes ☐ No ☐

Dental Coverage Interest: Yes ☐ No ☐ Vision Coverage Interest: Yes ☐ No ☐

Satisfaction with current plan:_____ What is most important to you?_____

_____

Spouse Insurance Information

Company Name: _____Premium: _____

PCP Copay: _____ Deductible: _____ Maximum: _____

Medicare #:_____ Part A Effective Date: _____ Part B Effective Date: _____

Medical Information

Primary Care Physician: _____ Clinic: _____

Pharmacy: _____ Dentist: _____

Current health conditions: _____

Potential hereditary conditions:_____

Travel/Virtual Coverage Needs

Foreign: Yes ☐ No ☐ Domestic: Yes ☐ No ☐ States: _____

Virtual Visit Interest: Yes ☐ No ☐

Decisions and Next Steps

_____ _____

_____ _____

_____ _____