Medicare Part D – Plan Selection Information

Are you working with a Benefit Specialist? If so, who: ______________________________

Name: ______________________

Birth Date: ______________________

Address: ______________________

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Zip Code: ______________________

Have you relocated recently? ☐ Yes ☐ No

If yes, list old Zip Code: ______________________

Phone: ______________________

Do you have a Guardian, POA-Finance, or someone you authorize to speak on your behalf, if so please list below.

Name: ______________________

Relationship: ______________________

Phone: ______________________

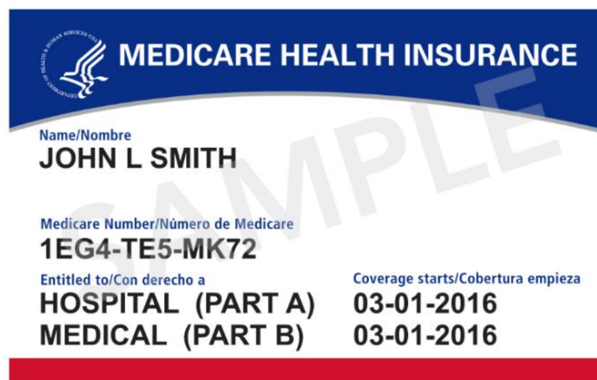
Are you new to Medicare? ☐ Yes ☐ No

Medicare #: ______________________

Effective Date Hospital A: ______________________

Effective Date Medical B: ______________________

** The information above can be found on your Medicare card, example below



Please write the FULL name of any Insurance you currently have (examples: SeniorCare, Supplemental Insurance, Medicare Advantage or Part D plan, Medicaid (Medical Assistance), Retiree/Employer coverage, etc. Please also indicate if you have a Low Income Subsidy w/Part D.

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Pharmacy – 1st Choice: ______________________

Pharmacy – 2nd Choice (optional): ______________________

Are Generic Medications okay? ☐ Yes ☐ No

Drug Name	Strength (mg/ml)	Dosage(1/day or 30/mo)

☐ I would like my plan choices mailed to me

☐ Call to review my plan choices

ADRC Aging & Disability Resource Center of St. Croix County

St. Croix County Wisconsin Innovation Through Cooperation