

## Waterford Senior Services Open Enrollment Worksheet For Part D

Complete this form and refer to it or bring it with you to your meeting.

Forms available at Senior Services, 24 Rope Ferry Road Waterford.

Call us to schedule your appointment. All information provided is **confidential**.

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

**Zoom/Phone/In-Person:** \_\_\_\_\_ **Email Address:** \_\_\_\_\_

Do you have Medicare coverage?  If no, will you have Medicare in the next 3 months?

Do you have Original Medicare? Yes  No

OR

Do you have a Medicare Advantage Plan (i.e. HMO, PPO, or Priv. Plan) Yes  No

If you are enrolled in a Medicare Advantage Plan please provide the company name and ID

#: \_\_\_\_\_

OR

What is your Medicare number: \_\_\_\_\_ **Bring your Medicare Card**

Do you have Part A? Effective Date: \_\_\_\_\_



Do you have Part B? Effective Date: \_\_\_\_\_

Current Medicare Rx Plan Name: \_\_\_\_\_

Medicare Rx Number (S \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_)

The State of CT pays my monthly Medicare Part B premiums. Yes  No

Do you have a Supplemental/Medigap policy? Yes  No

If yes, which one? \_\_\_\_\_ Monthly premium? \_\_\_\_\_

*List any other Insurance Plans that you have through an Employer, Retirement, etc.*

Insurance Company Name:

Hospital/Doctor Coverage  Prescription Coverage

Does your monthly income fall below \$2641.00 for Single

or \$3572.00 for Married couple? Yes  No

What pharmacy do you use? \_\_\_\_\_

**List your medications on the other side of this form.**

## Prescription List

Drug Name	Strength	Dosage per day	Quantity Ordered per month
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*Example: Lipitor*

10 mg.

1

30

*Take information from RX container.*

*Please print clearly.*

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