



MEDICARE OPEN ENROLLMENT **October 15th to December 7th**

Pre-Enrollment Form 2025

Bring this completed form to your appointment. If you do not have this completed form, your appointment may be rescheduled. SHIIP 919-742-3975

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: **NC** Zip: _____

Phone: _____ County: **Chatham** Year-Round Resident? Yes No

Email Address: _____ Primary Language: _____

Age: _____ Gender: _____ Race: _____ How did you hear about us: _____

Have you or immediate family member served in the military? Yes No

I am interested in reviewing my Part D Drug Plan. Yes No Advantage Plan? Yes No

Do you have a Supplement? Yes No Are you happy with your supplement? Yes No

Do you currently have other insurance coverage? Yes No If yes, Which? _____

Is this your first-time meeting with a SHIIP counselor? Yes No

If you need someone's assistance in decision making, please bring them to the meeting.

Have you established a Medicare.gov account?

If YES, make sure you have your login and password information available.

If NO, make sure you have your Medicare Card information available.

Medicare Card/Account Information

Name: _____ I prefer not to share this information,

Number: _____ but I will have this information with me.

Part A effective date: ____/____/____ Username: _____

Part B effective date: ____/____/____ Password: _____

Security question: _____ Answer: _____

Income/Subsidy/Pharmacy Information

Does your monthly income fall below \$1,883 (\$22,590 annually for single or \$2,555 (\$30,660 annually) for married couple? Yes No

Do your resources/assets fall below \$17,220 single or \$34,360 married? Yes No

What is your preferred pharmacy? _____ Alternative pharmacy? _____

Do you use mail order? Yes No

Are there any medications that are not covered by your current plan? Yes No _____

Are you currently receiving? Extra Help Medicaid Medicare Savings Plan

