







## 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: <u>NC</u> Zip:		
Phone:	County: <u>Chatham</u>	Year-Round Resident? ☐Yes ☐No		
Email Address:	Primary Language:			
ge: 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 D	rug 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? $\Box$ Yes $\Box$ No				
Do your resources/assets fall below \$17,220 single or \$34,360 married? ☐ Yes ☐No				
What is your preferred pharmacy?	Alter	native 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				

Please provide us with information about your prescriptions. Bring all your medications to your meeting.  NOTE: You may be able to obtain a computerized listing form your pharmacy to attach.			
Name of Drugs	Strength	Daily Dose	
Example: Lipitor	Example: 10 mg	Example: Twice Daily	
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Do you have any problems, comments, or concerns you would like to discuss?			
Appointment Preferences:			
I prefer Monday Tuesday Wednesday Thursday Friday Time:			
Will you need a Spanish speaking interpreter? $\square$ Yes $\square$ No			
I prefer to meet in person at Pittsboro Center Siler City Center			
or Piedmont Health in $\square$ Moncure $\square$ Siler City or $\square$ phone conference			