The Brokerage Resource
Insurance Marketing Organization

Medicare Supplement Client Fact Finder

Date:

Client Information:

First Name: Last Name:

Age: DOB:

Address:

City: State: Zip Code:

Phone: Email:

Spouse/Partner Information:

First Name: Last Name:

Age: DOB:

Medicare Information:

Currently working? Yes ☐ No ☐

*Covered through employer? Yes ☐ No ☐

Does your employer have 20 employees or more? Yes ☐ No ☐

*Covered by spouse's employer who is currently working? Yes ☐ No ☑

*Retiree coverage by your (or spouse's) former employer? Yes ☐ No ☑

Part A Effective Date: Part B Effective Date:

Medicare Supplement: ☐ Medicare Advantage: ☐

Current Plan Name:

Carrier Name:

Current Monthly Premium:

*You can only defer Parts A and B if your employer has 20 employees or more. Check with your employer's benefits adminstrator to determine how your coverage works with Medicare.

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Part D Information:

Current Part D Plan Name:

Carrier Name:

Plan Monthly Premium:

Current Prescriptions:

Health Information:

Tobacco: ☐ Non-Tobacco: ☐

Current Health Conditions: