SHICK Senior Health Insurance Counseling for Kansas

# MEDICARE PRESCRIPTION DRUG COVERAGE WORKSHEET

1. What is your name as it appears on your Medicare card? ①

   _____

2. What is your Medicare Claim Number? ②

   _____

3. What is your date of birth?

   _____
   *Month/Date/Year*

4. What is the effective date for your Medicare?

   ③Part A _____ ④Part B _____
   *Month/Date/Year* *Month/Date/Year*

5. What is your Zip Code?_____ County? _____

   Address, City, State _____

   Phone # _____

*Questions 6 & 7 are optional. This information can help determine if you are eligible for Extra Help with Medicare Part D costs.

6. Check the **ONE** box that best describes your **INCOME**.*

| Single, widowed, divorced or live apart from my spouse and: | Married and: |
|---|---|
| ☐ My annual gross income is less than $17,235 | ☐ Our annual gross income is less than $23,265 |
| ☐ My annual gross income is greater than $17,235 | ☐ Our annual gross income is greater than $23,265 |

7. Check the **ONE** box that best describes your **LIQUID ASSETS**. Liquid assets are the total value of your savings, investments and real estate. Do not include your primary home, vehicles, burial plots or personal possessions.*

| Single, widowed, divorced or live apart from my spouse and: | Married and: |
|---|---|
| ☐ My assets are $13,300 or less | ☐ Our assets are $26,580 or less |
| ☐ My assets are greater than $13,300 | ☐ Our assets are greater than $26,580 |

8. List the pharmacy or pharmacies you use. (Required)

   _____

Kansas Department for Aging and Disability Services

9. Which prescription drugs do you currently take? (Please also list the dosage, how often you take it per month and your monthly cost). **PLEASE PRINT CLEARLY. ATTACH AN EXTRA SHEET IF NEEDED.**

| DRUG NAME | DOSAGE | 30- DAY QUANTITY | MONTHLY COST |
|---|---|---|---|
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## SHICK Disclaimer

SHICK Counselor Name:_____ Telephone: _____

I have reviewed a minimum of three Medicare Part D Prescription Drug Plans and have chosen the following plan: _____. I give the SHICK Counselor listed above my authorization to enroll me in the above plan using the information I have provided. I confirm that all information provided is truthful and accurate and I hereby release the SHICK Counselor, the SHICK organization and the State of Kansas from any liability whatsoever, known or unknown, related or pertaining my Medicare Part D enrollment herein. I also acknowledge that information discussed with the Counselor cannot be relied upon nor construed as legal advice. I understand that I may not change my drug plan until the next open enrollment period which will be October 15, 2014 to December 7, 2014.

I also understand the costs and covered medications quoted on the plan I've chosen may be subject to change.

Signature: _____Printed Name: _____

Date: _____Drug List ID: _____Password Date: _____

**Office Use Only:**