



# Medicare Open Enrollment

Thank you for contact the Kenosha County Aging and Disability Resource Center to provide assistance to you during Medicares Open Enrollment Period for Medicare Prescription Drug Plans (Part D) and Medicare Advantage Plans (Part C). Please take a moment to complete the below information so a Benefit Specialist or Volunteer can better assist you.

## Name \*

<input type="text"/>	<input type="text"/>	<input type="text"/>	
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First Name

Middle Name

Last Name

## Address

Street Address

Street Address Line 2

<input type="text"/>	<input type="text"/>
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City

State / Province

Postal / Zip Code

## Phone Number \*

Please enter a valid phone number.

## Birth Date \*

<input type="text"/>	<input type="text"/>	<input type="text"/>	
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Month

Day

Year

## Email

example@example.com

**Marital Status**

- Single/Never Married
- Divorced
- Widowed
- Separated
- Married
- 

**Medicare Information (please fill in below)**



**Medicare Number**

**Hospital Part A Start Date:**

**Medical Part B Start Date:**

**What is your current Medicare Prescription (Part D) or Medicare Advantage (Part C) plan? Please provide any important information you would like a Benefit Specialist to know.**

**Do you have any of the following (please check all that apply)?**

- SeniorCare
- Medicare Medigap Supplemental Policy
- Employer/Retiree Coverage
- Medicaid (forward health card)
- VA Coverage (veterans)
- Other

**MyMedicare.gov** is Medicare's free, secure, online service for managing personal information regarding Original Medicare benefits and services. Original Medicare beneficiaries can create an account with **MyMedicare.gov** and use it to check information about their coverage, enrollment status, and Medicare claims. During Open Enrollment, using a **MyMedicare.gov** account allows Medicare beneficiaries to compare Medicare Options more accurately. MyMedicare.gov provides access to current and past Medicare plan coverages, as well as prescriptions filled by the beneficiary under a Medicare prescription plan.

**Do you have a MyMedicare.gov account?**

- Yes, I have a MyMedicare.gov account
- No, I do not, but I would like assistance creating one
- No, I do not, but I will create an account on my own (please locate the yellow colored sheet located in the packet, on how to create a MyMedicare.gov account)
- No, I do not have one and do not want to create an account

If you answered "**Yes**" to having a MyMedicare.gov account, or you created one on your own, please provide the information below. This will allow for a Benefit Specialist to assist you with your Open Enrollment Options. All information is confidential and will be kept in a secured case file.

**Medicare.gov Username:**

**Medicare.gov Password:**



Please fill in the circle, if you do not wish to provide the information on this form and would like a Benefit Specialist or Volunteer to call you to request this information.

If you answered "**NO**" to having a MyMedicare.gov account, and would like a Benefit Specialist from the Aging and Disability Resource center to assist you by creating one on your behalf, please sign below by typing your name. This will allow for a Benefit Specialist or Volunteer to assist you with your Open Enrollment Options. All information is confidential and will be kept in a secured case file.

**Signature**

# Prescription Drug Information

In this section, you will be able to provide all current or anticipated prescription drugs that you have or will have. In addition, please choose up to 5 pharmacies of your choice. Pharmacies are important when comparing Medicare options, as some Medicare plans have cheaper prices at a specific pharmacy if it is their preferred pharmacy within their network. Please use an additional sheet of paper, if you have more than 13 prescriptions.

	Prescription Drug Name (please provide information from your pharmacy or on the prescription bottle)	Dosage of Prescription	How often do you take the prescription?
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			

## Please select your Preferred Pharmacies (please choose up to 5)

- |                                      |                                     |                                 |  |
|--------------------------------------|-------------------------------------|---------------------------------|--|
| <input type="checkbox"/> Aurora      | <input type="checkbox"/> Concentra  | <input type="checkbox"/> Costco | <input type="checkbox"/> CVS               |
| <input type="checkbox"/> Good Value  | <input type="checkbox"/> Mail Order | <input type="checkbox"/> Meijer | <input type="checkbox"/> Modern Apothecary |
| <input type="checkbox"/> Pick N Save | <input type="checkbox"/> Sams Club  | <input type="checkbox"/> Target | <input type="checkbox"/> Walgreens         |
| <input type="checkbox"/> Walmart     | <input type="checkbox"/> Other      |                                 |  |

## Medicare Prescription (Part D) and Advantage (Part C) Disclaimer

Please read and sign the disclaimer below, to allow a Benefit Specialist or volunteer to assist you with Medicare Open Enrollment Options.

I understand that the benefit specialist or volunteer provides insurance options counseling based on information currently available at <https://www.medicare.gov/>, and based on information about personal prescription medications and pharmacy choices provided to the benefit specialist or volunteer. I also understand that information on the Planfinder site may not always reflect accurate and/or the most up-to-date information.

I understand that the Benefit Specialist or volunteer cannot advise me to choose one plan over another, and that it is up to me to decide and enroll in a plan of my choice, based on my needs and preferences. I also understand that enrollment in the plan must take place within my initial enrollment period, special enrollment period, or open enrollment period, or I may risk incurring a late enrollment penalty, be without needed coverage, and/or not be able to make changes until the next opportunity for enrollment occurs.

It is my responsibility to follow up with the plan of my choice if I have any questions. I will not hold the Benefit Specialist or Volunteer liable for any or all consequences that will result from my choice of plan.

By signing below you are acknowledging these statements and accepting services by the Benefit Specialist Program.

### Signature

Thank you for taking the time to complete the requested information. Please submit the packet to the Kenosha Aging and Disability Resource Center.

By Email: [Andrea.Taylor@kenoshacounty.org](mailto:Andrea.Taylor@kenoshacounty.org)

By Fax: 262-605-6649

By Mail: 8600 Sheridan Road

Kenosha, WI 53143

A Benefit Specialist or Volunteer will follow up with you after receiving your information. If there are questions, please contact the Aging and Disability Resource Center at 262-605-6652.