NC DEPARTMENT OF INSURANCE
SENIORS' HEALTH INSURANCE INFORMATION PROGRAM

DATE RETURNED: _____

(828) 758-2883

THE SATIE AND J.E. BROYHILL
Caldwell Senior Center

Once Completed, Return This Form To: Caldwell Senior Center

A SHIIP Counselor will contact you for an appointment upon receiving this form. Thank you.

650-A Pennton Ave., SW Lenoir
(or mail to: PO Box 933 Lenoir, NC 28645)

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ ETHNICITY: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ COUNTY: _____ YEAR-ROUND RESIDENT? __ Yes __ NO

EMAIL: _____

How did you hear about us? _____ PRIMARY LANGUAGE: _____

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

Medicare Card Information	Medicare.gov Account Info
Name:	**See back of form for more information.**
Number:	Username:
Part A effective date:	Password:
Part B effective date:	Security Question:
I need a new Medicare card. __Yes __ No	Answer:

Income/Subsidy Information	Pharmacy Information
Does your monthly income fall below $1,610 for Single or $2,178 for Married couple? __Yes __ No Do your Resources/Assets fall below $13,290 for Single or $26,520 for Married couple? __ Yes __ No Are you currently receiving: __ Extra Help __ Medicaid __ MQB Medicare Savings Plan	What is your preferred Pharmacy? _____ Alternative Pharmacy? _____ Are there any medications that are not covered by your current plan? __ Yes __ No If so, please list: _____ _____

Appointment Preferences:

I prefer __ Mornings __ Afternoons What time works best for you?

I would prefer to have a __Phone appointment __ Video chat __ In-person appointment

Please provide us with information about your prescriptions and pharmacy.

NOTE: You may be able to obtain a computerized listing from your pharmacist/pharmacy to attach. If not, please complete the chart below. Please attach additional sheets if needed.

Name of Drugs	Strength	Daily Dose
Example: Lipitor	***Example: 10 mg.***	***Example: Twice daily***

If needed I am authorizing SHIIP to assist me in creating an online Medicare account, or to access my current account, in order to create or update my drug list and compare Medicare Part D and/or Medicare Advantage plans, and I am authorizing SHIIP to securely store the Username for my Medicare account in order to assist me with plan comparisons or other Medicare enrollment or claims issues now and in the future upon my request.

____ YES ____ NO

I understand that if I decline I will only be provided with general information and that my results may not be as accurate as a personalized comparison.

____ YES ____ NO

Signature: _____