

ATTACHMENT 1

Medicare Advantage Enrollment Suitability Form
[Company name]
[Type of Plan]

Current Coverage

New to Medicare _____ Original Medicare _____ Medicare Advantage _____

Circle one: HMO PPO PFFS MSA

Plan name: _____

Drug benefit included? Yes _____ No _____

Need to change doctors? Yes _____ No _____

Need to buy Part D plan? Yes _____ No _____

[Medical group] [doctor] I need to use _____

Hospital I need to use _____

Reason for replacement

Better benefits:
Example _____

Lower cost (out of pocket)
Example: Existing \$ _____ Replacement \$ _____

Lower premium
Existing: \$ _____ Replacement \$ _____

Other:
Specify _____

Applicant: _____ Address _____

Agent: _____ License # _____

Date: _____

One copy must be left with applicant.
One copy must be sent to company with application.
One copy must be retained in agent records.