

Medicare Questionnaire

Section 1 I am interested in discussing with a Butler Capital Advisors representative my options regarding:

- | | | |
|---|---------------------------|-------|
| <input type="checkbox"/> Medical Coverage | Current Coverage: Medical | _____ |
| <input type="checkbox"/> Prescription Drug Coverage | Prescription | _____ |
| <input type="checkbox"/> Dental Coverage | Dental | _____ |
| <input type="checkbox"/> Vision Coverage | Vision | _____ |

Section 2 Please complete the information below. While this information is *not required*, complete answers are helpful in order to process any of the above requests.

Name: _____

(Primary Residence) Street: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: _____ E-Mail Address (if applicable): _____

Date of Birth: _____ Social Security #: _____

Medicare #: _____ Effective date (Part A): _____

Effective date (Part B): _____

Section 3 If you have a second home or place of residence, please complete the following:

Street: _____

City: _____ State: _____ Zip: _____

Section 4 If you are requesting information regarding **Medicare Part D Prescription Drug Plans**, please complete the following regarding current medications you are taking (*required*).

<u>Name of Prescription</u> (check <input checked="" type="checkbox"/> the box if you take the generic version)	<u>Dosage</u>	<u>Quantity/Month</u>
<input type="checkbox"/> _____	_____	_____
<input type="checkbox"/> _____	_____	_____
<input type="checkbox"/> _____	_____	_____
<input type="checkbox"/> _____	_____	_____
<input type="checkbox"/> _____	_____	_____
<input type="checkbox"/> _____	_____	_____



Please submit completed form to:

Butler Capital Advisors
28350 Kensington Lane
Perrysburg, OH 43551

Fax: 419.243.2695
Phone: 419.243.9665

Visit our website www.butlercapitaladvisors.com for more information!

Scope of Sales Appointment Confirmation Form

To be completed by person with Medicare.

Please initial below in the box beside the plan type that you want the agent to discuss with you. If you do not want the agent to discuss a plan type with you, please leave the box empty. (Please note that an agent may also discuss a Medicare Supplement policy with you.)

<input type="checkbox"/>	Stand-alone Medicare Prescription Drug Plans (Part D)
	Medicare Prescription Drug Plan (PDP) — A stand-alone drug plan that adds prescription drug coverage to the Original Medicare Plan, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans.
<input type="checkbox"/>	Medicare Advantage (Part C), Medicare Advantage Prescription Drug Plans, and other Medicare Plans
	Medicare Health Maintenance Organization (HMO) — A Medicare Advantage Plan that must cover all Part A and Part B health care. In most HMOs, you can only go to doctors, specialists, or hospitals in the plan's network except in an emergency.
	Medicare Preferred Provider Organization (PPO) Plan — A type of Medicare Advantage Plan available in a local or regional area in which you pay less if you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost.
	Medicare Private Fee-For-Service (PFFS) Plan — A type of Medicare Advantage Plan in which you may go to any Medicare-approved doctor or hospital that accepts the plan's payment and terms and conditions.
	Medicare Special Needs Plan (SNP) — A special type of Medicare Advantage Plan that provides more focused and specialized health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or have certain chronic medical conditions.
	Medicare Medical Savings Account (MSA) Plan — MSA Plans combine a high deductible Medicare Advantage Plan and a bank account. The plan deposits money from Medicare in the account. You can use it to pay your medical expenses until your deductible is met.
	Medicare Cost Plan — A type of health plan. In a Medicare Cost Plan, if you get services outside of the plan's network without a referral, your Medicare-covered services will be paid for under the Original Medicare Plan (your Cost Plan pays for emergency services, or urgently needed services).

By signing this you are agreeing to a sales meeting with a sales agent to discuss the specific types of products you initialed above. The person that will be discussing plan options with you is either employed or contracted by a Medicare health plan or prescription drug plan that is not the Federal government, and they may be compensated based on your enrollment in a plan.

Signing this does NOT affect your current enrollment, nor will it enroll you in a Medicare Advantage Plan, Prescription Drug Plan, or other Medicare plan.

Beneficiary Signature: _____

If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

Phone number: _____

Relationship to Beneficiary: _____

To be completed by Agent:

Agent Name:	Agent Phone:
Beneficiary Name:	Beneficiary Phone:
Beneficiary Address:	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.)	
Agent's Signature:	

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