Insurance Fact Sheet

Today's Date:_____

WHEN COMPLETED, PLEASE RETURN TO THE FRONT DESK ALONG WITH YOUR MEDICARE CARD.

REFERRED BY _____ PRIMARY AGENT _____

NAME _____ **DOB** _____

SSN _____ **TOBACCO** Y or N ☐ **HT** _____ **WT** _____

H. PHONE _____ **EMAIL** _____

C. PHONE _____

SPOUSE _____ **DOB** _____

SSN _____ **TOBACCO** Y or N ☐ **HT** _____ **WT** _____

H. PHONE_____ **EMAIL** _____

C. PHONE _____

HOME ADDRESS _____

CITY_____ **STATE**_____ **COUNTY**_____ **ZIPCODE**_____

P.O. BOX _____ **CITY** _____ **STATE** _____ **ZIP** _____

PREFERRED NETWORK MERCY COX FREEMAN NO PREFERENCE

PREFERRED PHARMACY _____

PRIMARY CARE PHYSICIAN _____

PLEASE CHECK THE FOLLOWING GAP COVERAGE YOU WOULD LIKE TO DISCUSS WITH YOUR AGENT

DENTAL/VISION/HEARING ☐ CRITICAL ILLNESS ☐

HOSPITAL INDEMNITY ☐ LIFE INSURANCE ☐

CANCER/STROKE/HEART ☐ FINAL EXPENSE ☐

HOME HEALTHCARE ☐ SHORT TERM CARE ☐

SELECT ALL THAT APPLY TO YOU

MARRIED ☐ INTERNET USER ☐ VETERAN ☐

SINGLE ☐ SOCIAL MEDIA USER ☐ WIDOWED ☐

OTHER INTERESTS _____

PLEASE SHARE HOW WE HAVE HELPED YOU _____

MAY WE SHARE YOUR TESTIMONY? _____

WOULD YOU RECOMMEND OUR SERVICES TO OTHERS? _____

All information is confidential and for office use only.

5/5/2021