MEDICARE PART D ENROLLMENT

INFORMATION

Date:	Marital Status: *(Please circle)*
Pharmacy:	Married Single Divorced Widowed Separated

Name (as printed on Medicare card):

Phone:	Date of birth:	County:
Current address:		
City:	State:	Zip Code:
Medicare #:	Medicare Effective Dates: Part A: Part B:	VA benefits:*(Please circle)* Yes No Maybe

SPOUSE'S INFORMATION – COMPLETE ONLY IF APPLYING

Spouse Name (as printed on Medicare card):	
Phone: (If different from above)	Date of birth:
Address: (If different)	

City:	State:	Zip Code:
Medicare #:	Medicare Effective Dates: Part A: Part B:	VA benefits:*(Please circle)* Yes No Maybe

DO YOU HAVE

MO RX PLAN: *(Please circle)*	EXTRA HELP: *(Please circle)*	QMB: *(Please circle)*
Yes No Maybe	Yes No Maybe	Yes No Maybe

EMERGENCY CONTACT

Name:
Phone #:

MEDICARE PART D ENROLLMENT		
Prescription	Dosage	Number of Times Taken Daily

Mail To:

Aging Matters

1219 N. Kingshighway, Suite 100

Cape Girardeau, MO 63701

573-335-3331