# MEDICARE PRESCRIPTION DRUG COVERAGE WORKSHEET

1. What is your name as it appears on your Medicare card? ①

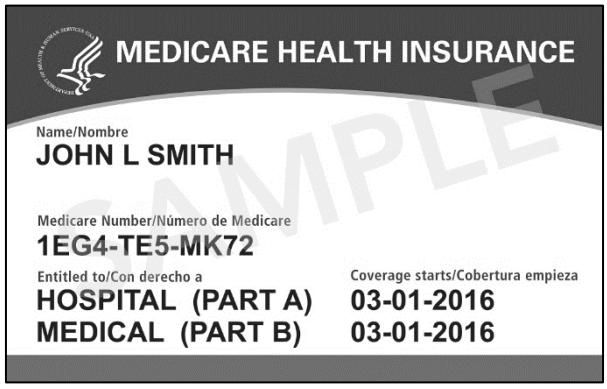
   _____

2. What is your Medicare Claim Number? ②

   _____

3. What is your date of birth?

   _____
   *Month/Date/Year*



① ② ③ ④

4. What is the effective date for your Medicare?

   ③Part A _____ ④Part B _____
   *Month/Date/Year* *Month/Date/Year*

5. What is your Zip Code?_____ County? _____

   Address, City, State _____

   Phone # _____

*Questions 6 & 7 are optional. This information can help determine if you are eligible for Extra Help with Medicare Part D costs.

6. Check the **ONE** box that best describes your **INCOME**.*

| Single, widowed, divorced or live apart from my spouse and: | Married and: |
|---|---|
| ☐ My annual gross income is less than $19,320 | ☐ Our annual gross income is less than $26,130 |
| ☐ My annual gross income is greater than $19,320 | ☐ Our annual gross income is greater than $26,130 |

7. Check the **ONE** box that best describes your **LIQUID ASSETS**. Liquid assets are the total value of your savings, investments and real estate. Do not include your primary home, vehicles, burial plots or personal possessions.*

| Single, widowed, divorced or live apart from my spouse and: | Married and: |
|---|---|
| ☐ My assets are $14,790 or less | ☐ Our assets are $29,520 or less |
| ☐ My assets are greater than $14,790 | ☐ Our assets are greater than $29,520 |

8. List the pharmacy or pharmacies you use. (Required)

   _____

9. Which prescription drugs do you currently take? (Please also list the dosage, how often you take it per month and your monthly cost). **PLEASE PRINT CLEARLY. ATTACH AN EXTRA SHEET IF NEEDED.**

| DRUG NAME | DOSAGE | 30- DAY QUANTITY | MONTHLY COST |
|---|---|---|---|
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## SHICK Disclaimer

SHICK Counselor Name:_____ Telephone: _____

I have reviewed a minimum of three Medicare Part D Prescription Drug Plans and have chosen the following plan: _____. I give the SHICK Counselor listed above my authorization to enroll me in the above plan using the information I have provided. I confirm that all information provided is truthful and accurate and I hereby release the SHICK Counselor, the SHICK organization and the State of Kansas from any liability whatsoever, known or unknown, related or pertaining my Medicare Part D enrollment herein. I also acknowledge that information discussed with the Counselor cannot be relied upon nor construed as legal advice. I understand that I may not change my drug plan until the next open enrollment period which will be October 15, 2022 to December 7, 2022

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I also understand the costs and covered medications quoted on the plan I've chosen may be subject to change.

Signature: _____ Printed Name: _____

Date: _____ Drug List ID: _____ Password Date: _____