H&H HARDING HARDING & ASSOCIATES, INC.
LONG-TERM CARE AND MEDICARE PLANNING SOLUTIONS

Medicare Supplement Quote Request

Date: _____ **AGENT NAME**: _____ Email: _____

Client: _____

Date of Birth: _____

Address: _____

_____

Sex: Male / Female

Tobacco: Yes / No

Part A Effective Date: _____

Part B Effective Date: _____

Enrolling During: Open Enrollment / Special Protection / Full Underwriting

Effective Date of Coverage: _____

Medications: Quantity: _____

- Any Changes in last 2 yrs? Yes / No

Medications: *Please List*

_____

_____

_____

_____

_____

Health Concerns:

_____

_____

_____

_____

_____

Spouse: _____

Date of Birth: _____

Address: _____

_____

Sex: Male / Female

Tobacco: Yes / No

Part A Effective Date: _____

Part B Effective Date: _____

Enrolling During: Open Enrollment / Special Protection / Full Underwriting

Effective Date of Coverage: _____

Medications: Quantity: _____

- Any Changes in last 2 yrs? Yes / No

Medications: *Please List*

_____

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Health Concerns:

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_____

_____

Requested Medigap Plans: A | B | C | D | F | G | K | L | M | N

FAX: (330) 499-5829
Call: (330) 499-5824
Email: sbh@hardingharding.com