**Please submit details of Husband and Wife**

# Client Information for MEDIGAP/Supplement Plan

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Self** | | | | | | | | | | |
| **First Name:** | | | Middle: | | | Last: | | | | |
| Date of Birth |  | | | **Social Security number** | | | | | |  |
| Gender | **F M** | | | **Smoker** | | | | | | **Y N** |
| Height | **Fts in** | | | **Weight** | | | | | | **Lbs** |
| **Address** | Zip Code: | | | | County: | | | | | |
| Street: | | | | City: State: | | | | | |
| **Phone & Email** | Home: | | | | Cell: | | | | | |
| Email: | | | | | | | | | |
| **Medicare Number** |  | | | Part A effective date: | | | | | Part B effective date: | |
| **Current Insurance:** | | | | Plan: | | | | | | |
| **Employer Coverage** | Y N | | | End Date: | | | | | | |
| **Company to join** |  | | | Plan: | | | | Effective Date: | | |
| **Bank Name:** | | Routing #: | | | | | A/C #: | | | |
| **Spouse Information** | | | | | | | | | | |
| **First Name:** | | | Middle: | | | Last: | | | | |
| **Date of Birth** |  | | | Social Security number | | | | |  | |
| **Gender** | F M | | | Smoker | | | | | Y N | |
| **Height** | Fts in | | | Weight | | | | | Lbs | |
| **Phone & Email** | Home: | | | | Cell: | | | | | |
| Email: | | | | | | | | | |
| **Medicare Number** |  | | | Part A Effective Date: | | | | | Part B Effective Date: | |
| **Current Insurance:** | | | | Plan: | | | | | | |
| **Employer Coverage** | Y N | | | End Date: | | | | | | |
| **Company to join** |  | | | Plan: | | | | Effective Date: | | |
| **Address if it’s different than above** |  | | | | | | | | | |

By providing this Information you are authorizing **Health Life 360 LLC** to contact you in future to address all your medicare needs.

**Signature:**  **Date:**