TLC INSURANCE GROUP & WEALTH

TLC Insurance Group / Client Management Service Form

Writing Agent _____Phone:_____

SUBMITTED BY AGENT DIRECT TO CARRIER: YES☐ NO☐

CLIENT NAME: First _____Last _____MI_____

DOB_____/_____/_____ M☐ F☐

Medicare #: _____ Social Security #: _____

Part A Eff: _____ Part B Eff: _____

Phone H: _____ Phone C: _____

Address: Street_____

City: _____State_____ Zip: _____

County: _____

PLEASE USE ONE FORM PER CLIENT- SECOND CARRIER SPACE PROVIDED IF CLIENT IS ENROLLING IN MEDICARE SUPP & PDP OR MAPD AND HOSPITAL INDEMNITY

Carrier: _____ Carrier: _____

Plan Name: _____ Plan Name: _____

Effective Date: _____ Effective Date: _____

Premium (if any): _____ Premium (if any): _____

App submission (select one): ○ ***Online*** ○ ***Paper*** **App submission** (select one): ○ ***Online*** ○ ***Paper***

Medicare.gov drug list id#_____ Date_____

Preferred Pharmacy: _____

Current Client_____ New Client_____

Retired from Packard/Delphi/IUE Retiree, Spouse, or Surviving Spouse: Yes☐ No☐

If Yes is the client the: (Circle One) Retiree Spouse Surviving Spouse

NAME OF THE RETIREE: (If Applicant is the Spouse):_____D.O.B._____

All information will be held secure, private and confidential. Required for servicing of policies. Form: TLC – Agency BlocREV73118