MY CURRENT MEDICARE COVERAGES, PROVIDERS, AND MEDICATIONS

GRISET MEDICARE SOLUTIONS

Please complete as much of this form to the best of your knowledge. We will contact you to discuss any further information required. This information will be kept and protected for the sole and confidential use of Griset Medicare Solutions.

Personal Information

FIRST NAME	MIDDLE INITIAL	LAST NAME	AGE
STREET ADDRESS			UNIT/APT NO.
CITY	ZIP CODE	PRIMARY PHONE	
EMAIL ADDRESS		MOBILE PHONE	
EFFECTIVE DATES OF MEDICARE Part A: Part B:			DATE OF BIRTH

Coverages of Interest: ☐ Hearing ☐ Vision ☐ Dental ☐ Gym Membership

Current Medicare Plan Coverages

HEALTH PLAN	PREMIUM / MONTH $
MEDICATION PLAN	PREMIUM / MONTH $
DENTAL PLAN	PREMIUM / MONTH $
VISION PLAN	PREMIUM / MONTH $

PRIMARY PHYSICIAN NAME	
LOCATION	PHONE NUMBER

MEDICAL SPECIALIST NAME	SPECIALTY TYPE
LOCATION	PHONE NUMBER

MEDICAL SPECIALIST NAME 2	SPECIALTY TYPE
LOCATION	PHONE NUMBER

MEDICAL SPECIALIST NAME 3	SPECIALTY TYPE
LOCATION	PHONE NUMBER

DENTIST NAME	LOCATION

HOSPITAL PREFERENCE	LOCATION

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Current Maintenance Medications

MEDICATION NAME (e.g. Lipitor)	STRENGTH (e.g. 250 mg)	DOSAGE (e.g. 1/day)

PHARMACY PREFERENCE	LOCATION	MAIL ORDER ☐ Yes ☐ No

Modified Adjusted Gross Income in 2024

Individual Filing Amount		Joint Filing Amount	
☐ $109,000 or less	☐ $171,001 - $205,000	☐ $218,000 or less	☐ $342,001 - $410,000
☐ $109,001 - $137,000	☐ $205,001 - $500,000	☐ $218,001 - $274,000	☐ $410,001 - $750,000
☐ $137,001 - $171,000	☐ $500,000 or above	☐ $274,001 - $342,000	☐ $750,000 or above

By submitting this form, you agree that Daniel Griset, a licensed and independent agent, is invited to contact you by email or phone to discuss your Medicare options, including Medicare Advantage, Medicare Supplement, and Prescription Drug plans.

Form Submittal Options

We invite you to submit your completed form in any one of the following methods you feel most comfortable:

Email Submittal	If you've completed this "fillable" form on your computer, save the completed form to your Desktop and send it as an attachment to Dan@GrisetMedicare.com. If you've completed it by hand and can scan it, also email it to Dan@GrisetMedicare.com.
Text Submittal	If completed by hand, take clear pictures of both sides/pages and text the pictures to **(714) 973-2100**.
Print and Fax	Fax your completed form to **(714) 442-0124**
Print and Mail	Mail your completed form to: **Griset Medicare Solutions** P.O. Box 4062 Santa Ana, CA 92702