

NCRO Medicare Questionnaire

I am interested in discussing with the Ralph Wilson Agency my options regarding Medicare Coverage.

Please complete the information below. While this information is not required, complete answers are helpful in order to provide you with the best service possible.

Name: _____

Primary Residence: _____

Phone: _____ E-Mail: _____

Date of Birth: _____

Effective date (Part A): _____ Effective date (Part B): _____

If you have a second home or place of residence, please complete the following:

Street: _____ City: _____ State: _____

Zip: _____ County: _____

If you are requesting information regarding **Medicare Part D Prescription Drug Plans**, please complete the following regarding current medications you are taking.

<u>Name of Prescription (please indicate if generic)</u>	<u>Dosage</u>	<u>Quantity/Month</u>
• _____	_____	_____
• _____	_____	_____
• _____	_____	_____
• _____	_____	_____
• _____	_____	_____
• _____	_____	_____

Please submit completed form to:

Ralph C. Wilson Agency
Attn.: Bill Percha
26026 Telegraph Rd., Ste. 100
P.O. Box 5969
Southfield, MI 48086

Fax: 248-355-9169
Phone: 248-355-1414 ext 140



RALPH C. WILSON AGENCY, INC
INSURANCE EXCELLENCE