



Ask the Right Questions: Talking to an Insurance Agent about a Plan

If you are thinking about changing your Medicare coverage, work together with your insurance agent to complete this form and decide if the plan is right for you. If you have questions or need help, call the Illinois SMP at AgeOptions: **(800)699-9043**.

Plan Information:

Date: _____

What is the name of the plan? _____

How did I hear about the plan? _____

The plan I am interested in is a:

- | | |
|---|--|
| <input type="checkbox"/> Medicare Advantage plan - Health Coverage ONLY | <input type="checkbox"/> Medicare Advantage plan - Health and Prescription Drug Coverage |
| <input type="checkbox"/> Medicare Prescription Drug plan | <input type="checkbox"/> Medicare Supplement plan |

Has the agent given me a written description of the plan? YES NO

If the plan is a Medicare Advantage plan:

Does the plan include Prescription Drug (Part D) coverage? YES NO

How much will my monthly premium payment be? \$ _____

Will I still have to pay my Part B premium? YES NO

Have I asked all my medical providers (doctors, hospitals, etc.) if they accept the plan? YES NO

What will my co-payments be for:

Doctor visit \$ _____

Hospital stay \$ _____

Prescription drugs \$ _____

Can I return to Original Medicare at any time? YES NO

If the plan is a Medicare Supplement plan:

How much will my monthly premium payment be? \$ _____

What benefits does the plan cover? _____

If the plan covers Prescription Drugs:

How much will my monthly premium payment be? \$ _____

What will my co-payments be? _____

Are all of my drugs covered? YES NO

Do any of my drugs require prior authorization, step therapy, or quantity limits? YES NO

If so, which drugs? _____

What are the rules? _____

Have the agent complete the section below

Agent/Broker Name _____ Phone _____

Plan and Company Name _____

Company Address _____

Agent's Illinois Insurance License Number _____

The plan I am offering is:

- Medicare Advantage plan - Health Coverage ONLY
- Medicare Advantage plan - Health and Prescription Drug Coverage
- Medicare Prescription Drug plan
- Medicare Supplement plan

Agent /Broker Signature _____ Date _____

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