Medicare Annual Open Enrollment Period: October 15-December 7

How Do I Compare My Plan Options?

Option 1: Do-It-Yourself

Once you have completed the Medicare Plan Finder Information, you can use it to find and enroll in a Medicare drug plan that meets your needs:

Online:	By Contacting the plan of your choice:
by using Medicare's Plan Finder at www.Medicare.gov. It will guide you through the process	Plan contact info is on the Plan Finder's plan details
Assistance is also available through: ▪ 1-800-MEDICARE (1-800-633-422) or www.Medicare.gov ▪ The Medigap Helpline 1-800-242-1060 ▪ Medigap Part D and Prescription Drug Helpline 1-855-677-2783, for WI residents 60+ ▪ Disability Rights Wisconsin Medicare Part D Helpline 1-800-926-4862, for ages 18-59	

Option 2: If You Would Like Local Assistance:

Complete and return both of the enclosed forms (2 forms):

By Mail or Drop off:	By Fax:
ADRC of Door County Attn: SHIP 916 N 14th Avenue Sturgeon Bay, WI 54235	920-746-7150

Once Your Forms are Received, a Benefit Specialist/SHIP Counselor will:

1. Run the Medicare Plan Finder with the information you provided;
2. Mail, email or have ready for pick up, Plan Finder results for your review (please make sure to check which option you prefer on the worksheet);
3. Contact you to review the results, or schedule a time to review the results of the Plan Finder with you if that is the selection you've made on the worksheet.

The Benefit Specialist and SHIP Program Volunteers will provide free, unbiased information about your plan options. We are unable to give recommendations as to what plan you should choose.

Open Enrollment Plan Comparison Request
Medicare Account Information-Please Check One Option

❒ **I <u>have</u> a Medicare.gov account** and authorize the Benefit Specialist Program to access, update and utilize my account in order to create my personalized Medicare.gov Plan Finder comparison.

Medicare already has your information. Allowing the Benefit Specialist to access your Medicare.gov account makes the comparison process much quicker and simpler. In order to create a personalized plan comparison for you, you must have a Medicare.gov account. Please circle which letter applies to you:

❍ My username and password are listed below (Please print clearly)**:**

My Known Medicare.gov Account Info:	User Name:
	Password:

<u>OR</u>

❍ The Door County Benefit Specialist Program helped me create a Medicare.gov account in a prior visit. Please check my file.

❒ **I <u>do not currently have</u> a Medicare.gov account**, **and authorize the Benefit Specialist Program to create one** for me. I authorize the Benefit Specialist Program to then access and utilize my Medicare,gov account in order to create my personalized Medicare.gov Plan Finder comparison. I have answered the below questions so my account can be set up to my preferences as much as possible. I understand requested usernames and passwords will be adjusted if not available.

What would you ***like*** for your username? (Passwords must be a minimum of 8 character):
What would you ***like*** for your password: (Passwords must be 8-16 characters; Contain at least 1 letter, 1 number and 1 character @ ! $ % " *)
Secret Questions: Please choose **one (1)** of the following and answer it: ☐ Your favorite vacation spot? ☐ City that you first meet your spouse? ☐ Country you would most like to visit? ☐ Title of your favorite book? ☐ The name of the first street you lived on? ☐ The name of your first pet? ☐ Your best friend's last name?

❒ **I do not authorize the Benefit Specialist Program to use my Medicare.gov account.** Please complete a Plan Finder comparison without using my Medicare.gov account**.** I understand my information will not be saved or accessible in the future and that the Benefit Specialist will only be able to input and complete one plan comparison this year regardless of any corrections/changes to the original submitted form or of any input error.

<u>Please double check for completeness. incomplete forms will be returned or cause delays and cause incomplete results</u>

If it is your choice that we use your personalized MyMedicare account, please sign the statement below:

By signing this form, I give the ADRC Benefit Specialist Program permission to store my Medicare.gov username and password for use of helping me compare or review my Medicare plan.

Your username and password will be kept in your secure client file. Neither the Elder/Disability Benefit Specialist, nor the ADRC will use your username and password to access your Medicare.gov account without your permission.

You have the right to request your username and password from the Benefit Specialist program at any time. You have the right to change your username and password at any time. You have the right to revoke this consent at any time by contacting the ADRC at 920-746-2372.

_____ _____

Client signature Date

_____

Client name – printed

Please double check for completeness. incomplete forms will be returned or cause delays and cause incomplete results

Medicare Advantage Plan or PDP Comparison Request Form

* I am requesting assistance from the Elder Benefit Specialist, Disability Benefit Program, and SHIP Volunteer Counselors in gathering Medicare Advantage or Part D plan options from Medicare.gov Plan Finder. I understand:
* Enrollment into an Advantage Plan or Part D Plan can only be done during a person's Medicare initial enrollment period; Medicare's annual open enrollment period; Medicare's Advantage open enrollment; or during one of Medicare's special enrollment periods.
* The Plan Finder provides **estimates** ONLY. I understand I am strongly advised to call a plan directly to confirm that the information I am relying on from the Plan Finder is accurate.
* This form is only a screening tool and NOT an actual application for a plan.
* I am responsible for my own enrollment. Although the Benefit Specialist can assist me with enrolling, it is my responsibility to assure that I have been enrolled. Elder/Disability Benefit Specialist or SHIP Volunteer enrollment assistance into a plan is not a recommendation as to which plan is best for me.

Comparison You Are Requesting:

❒ **Advantage Plan WITH drug coverage**

❒ **Prescription Only Plan (PDP)-Original Medicare**

❒ **Advantage Plan WITHOUT drug coverage**

I Would Like My Results:

❒ **I would like my plan comparison sent to me and I will enroll myself**

❒ **Reviewed with a Benefit Specialist/SHIP Counselor for help with enrolling. Please Call me to set up an appointment**

Please PRINT information as clearly as possible.
Note: Spouses need to complete separate forms.

Name:		Birthdate:	
Street Address:		Age:	☐ Male ☐ Female
City:	State:	Zip Code:	
Mailing Address			
City:	State:	Zip Code:	
Email Address:	Phone #:		
Medicare ID number from your red/white/blue Medicare card:	Medicare Part A Effective Date:		
	Medicare Part B: Effective Date:		
Complete name **of your current *Advantage Plan or Part D Plan*** as printed on your card:		Next Page →	

Please double check for completeness. incomplete forms will be returned or cause delays and cause incomplete results

Preferred Pharmacy (Can compare up to five. If you want to compare more than 2 please use extra paper)

#1:	Location/City:
#2:	Location/City:

☐ I get my prescriptions by mail-order. ☐ I might get prescriptions by mail-order, if cheaper.

Medication List

- If you have more than 40 prescriptions, you will need to contact 1-800-Medicare for assistance.
- List below **current prescriptions that you want your prescription plan to help cover**. You could instead attach a printout from your pharmacy- but please review it for accuracy first. Cross out over-the-counter meds, meds you no longer take and meds that don't need to be covered in your plan. Use best estimate for "as needed" meds (even if 1 pill 1x/year). The Plan Finder **requires** this information and you will not get a good estimate if you are missing details. If you have more than 10 medications, please attach a separate page.

Current Prescription Name	Dosage and Type of medication	Quantity	Refilled how often?
Look at the prescription container closely and include the entire name listed on the label.	i.e. mg, mcg, ml, etc. i.e. Tablet, capsule, vial, tub, jar, pen, ointment, syringe, etc.	How many do you order at a time?	Monthly? Every 2 months? Every 3 mo.? Etc.
Example: Trulicity	1.5ml/.5ml solution pen injector	3 boxes of 4 pens	Every 2 months
Example: Glipizide/Metformin	2.5- 250mg tablets	60	Monthly
1			
2			
3			
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10			

I have read and agree with the information provided to me on this form. I understand that the Benefit Specialist Program is not making any recommendations into which plan I should enroll in, even if enrollment assistance is decided upon, and it is my responsibility to make sure that I am enrolled into the plan of my choosing.

_____ _____

Client signature Date

_____

Client name – printed

Please return this form and double check for completeness-incomplete forms will delay your results