INSURANCE GROUP & WEALTH

TLC Insurance Group / Client Management Service Form

Agent Name ______________________________ ***Phone:*** ____________________

CLIENT NAME: First ________________________ Last __________________________ MI_______

DOB: _________________ M____ F____ Email: ______________________________________

Medicare #: ____________________________ Social Security #: _________________________

Part A Eff: _____/______/_____________ Part B Eff: _____/______/_____________

Phone H: ______________________________ Phone C: __________________________________

Address: Street ____ Apt/Unit: _________

City: __________________________ State: _____ Zip: __________ County: __________________

Mailing Address: ____

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: ________________________________

Plan Name: _____________________________

Effective Date: __________________________

Premium (if any): ________________________

App submission (select one):

○ ***Paper*** *(Needs submitted by TLC include fax cover)*

○ ***Electronic Application by Agent*** *(Do NOT Send Fax Cover)*

**Date of Online Submission: ____/____/_______*

**Submission Confirmation #: __________________*

○ ***Copy of Paper App*** *(Agent submitted direct to carrier)*

Carrier: ________________________________

Plan Name: _____________________________

Effective Date: __________________________

Premium (if any): ________________________

App submission (select one):

○ ***Paper*** *(Needs submitted by TLC include fax cover)*

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**Date of Online Submission: ____/____/_______*

**Submission Confirmation #: __________________*

○ ***Copy of Paper App*** *(Agent submitted direct to carrier)*

INCLUDING ALL REQUESTED INFO WILL ASSIST WITH APPLICATION PROCESSING, SERVICE, GUIDANCE & APPLICATION ISSUES THAT COULD OCCUR POST SUBMISSION

Preferred Pharmacy: ________________________________

Group Name (If Applies): ____

Current Client:_____________________ New Client:_____________________

Retired from: _____________________ 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. __________________