CHAPMAN
insurance group, LLC

Fall Open Enrollment Check Up

What to do to review your plan?

Step 1. Review your Annual Notice of Change for your RX plan or Medicare Advantage plan.

Step 2. If there are changes that concern you contact us at 865-403-0744 to shcedule a review.

Step 3. Please fill out this entire form and bring it with you to your appointment.

Step 4. Bring these 4 important items with you:

Your Medicare Card

Your checkbook
(in case we make a change)

Completed Checklist

Your Current Insurance Card

Name: _____ D.O.B.: _____/_____/_____

Address: _____ Gender: _____

City: _____ State: _____ Zip Code: _____ County: _____

Home Phone: (_____)-_____ Cell Phone: (_____)-_____

What current medical plan do you have? Check all that apply.

☐ Medi-Gap ☐ Advantage Plan ☐ RX Plan

Do you travel? If so for what lentgh of time? _____

Please list you current doctors PCP and Specialistsw only:

PCP Name_____

Office Address_____

Specialist Name_____Type_____

Office Address_____

Specialist Name_____Type_____

Office Address_____

Specialist Name_____Type_____

Office Address_____

Please list all your current prescriptions as they are written on oyour medication bottles.
(List Generic name is used) List only medications prescribed by doctors.

Example: RX Name (lisinipril) Dosage (20mg) Frequency (1x per day)

RX Name:_____ Dosage:_____ Frequency:_____
RX Name:_____ Dosage:_____ Frequency:_____
RX Name:_____ Dosage:_____ Frequency:_____
RX Name:_____ Dosage:_____ Frequency:_____
RX Name:_____ Dosage:_____ Frequency:_____
RX Name:_____ Dosage:_____ Frequency:_____
RX Name:_____ Dosage:_____ Frequency:_____
RX Name:_____ Dosage:_____ Frequency:_____
RX Name:_____ Dosage:_____ Frequency:_____
RX Name:_____ Dosage:_____ Frequency:_____
RX Name:_____ Dosage:_____ Frequency:_____
RX Name:_____ Dosage:_____ Frequency:_____
RX Name:_____ Dosage:_____ Frequency:_____
RX Name:_____ Dosage:_____ Frequency:_____
RX Name:_____ Dosage:_____ Frequency:_____
RX Name:_____ Dosage:_____ Frequency:_____
RX Name:_____ Dosage:_____ Frequency:_____

Retail Pharmacy used 1._____ 2._____

Do you use Mail Order Pharmacy? Yes____No____

Authorization:

I have volintarily provided the health information in this form to CHAPMAN Insurance Group LLC. to assist in my plan review. I agree to recieve my personal no cost revie, I further autorize CHAPMAN Insurance Group LLC. to contact me by phone and email, if needed. This information provided to CHAPMAN Insurance Group LLC. on this form will not be used forpurposesother than written into this authorization. I understand I am not obligated to take CHAPMAN Insurance Group LLC. recommendations.

Signature / POA _____ Date_____/_____/_____