Axford
SENIOR MARKETING INC.

# Medicare Supplement Prequalification

Client Name: _____ Agent Name: _____

Client Height: _____ Agent Phone Number: _____

Client Weight: _____ Agent Email Address: _____

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Gender: M or F DOB or Age: _____ Zip Code: _____ Tobacco: Y or N

Do they live with anyone (Household discount available) Y or N Will they be applying? Y or N

Spouse/Live with: _____ Gender: M or F DOB or Age: _____ Tobacco: Y or N

Desired Effective Date: _____ Do you currently have a Medicare Supplement Policy? Y or N

If yes, Plan Type(F,G,N): _____ Carrier:_____ Premium Amount: $_____

**Health Conditions: (check only if it applies)**

**Diabetic?** Y N

If yes:

- ☐ Insulin Use & Dosage _____
- ☐ History of heart attack or stroke

Within the **LAST 3 YEARS** have you been medically diagnosed, treated or had surgery for:

- ☐ Atrial fibrillation
- ☐ Internal Cancer
- ☐ Melanoma
- ☐ Stroke
- ☐ Peripheral vascular
- ☐ Arthritis that restricts mobility or the activities of daily living
- ☐ Any lung or respiratory disorder requiring the use of a nebulizer or oxygen

Within **LAST 1 YEAR**

Have you been advised by a medical professional to have treatment, further evaluation, diagnostic testing, or any surgery that has not been performed? **Y** **N**

If yes, details: _____

Have you been medically diagnosed, treated or had surgery for:

- ☐ Heart attack
- ☐ Had a seizure

Return this form to Axford Senior Marketing for your personalized Med Sup quote.

**E-Mail:** axford@axfordsmi.com **Fax:** 308-384-0481 **Phone:** 888-396-2580

Any health concerns in the past 5 years? Y or N

If yes, details:

_____

If taking any prescription medication please list below, attach a separate page if needed.

| **Medication** | **Frequency & Dosage** | **Reason Taking** |
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Notes:

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