

2022 Part D Prescription Drug Plan Review Request

Name: _____ Daytime Phone Number: _____

Email Address: _____ Best Time to Contact: _____

Permanent Residence ZIP code: _____

- I understand that submitting my personalized list of prescription drugs is optional and I am volunteering this information to obtain an annual Medicare review to be completed by KMD Insurance Associates, LLC.
- I understand that my report will be emailed to me by a secure email. The documents will be available for 30 days. **Please access and/or save the reports within 30 days of receipt.**



My current Part D Prescription Drug Plan is: _____ / _____
Company Name Plan Name

Mail Order costs will be included and up to two retail pharmacies may be selected:



1. _____ 2. _____

Please do not include OTC or compounded medications or vitamins.

Medication Name	Please circle one	Dosage <i>(ex: 15 mg)</i>	Daily Usage Amount <i>(ex: 1 per day)</i>	OK to Use Generic?
	<i>Tablet or Capsule</i>			Yes or No
	<i>Tablet or Capsule</i>			Yes or No
	<i>Tablet or Capsule</i>			Yes or No
	<i>Tablet or Capsule</i>			Yes or No
	<i>Tablet or Capsule</i>			Yes or No
	<i>Tablet or Capsule</i>			Yes or No
	<i>Tablet or Capsule</i>			Yes or No

Drops/ Lotions/Creams:

Medication Name	Please circle one	Dosage	Usage <i>(ex: 1 tube/bottle every 3 months)</i>	OK to Use Generic?
	<i>Drops / Lotion / Cream</i>			Yes or No
	<i>Drops / Lotion / Cream</i>			Yes or No
	<i>Drops / Lotion / Cream</i>			Yes or No

(Please attach a sheet if more space is required.)



Signature: _____ Date: _____

By returning this form, I agree to allow a licensed sales representative to contact me regarding information related to Medicare health plans and health insurance plans, products, services and/or educational information related to health care. I understand that the person who will be discussing plan options with me may be compensated based on my enrollment in a plan. This is a solicitation for insurance.

Please use the secure link that has been provided to upload your completed form and send to Kevin Dougherty. If you need further assistance, please contact Liz Dougherty at Liz@KMDinsurance.com

If mailing via USPS: Kevin Dougherty, 1058 Edenton Dr, Calabash, NC 28467