

Client Information Form

Hoffoss Insurance Agency, 126 Canterbury Rd, Circle Pines, MN 55014

Office address: 2 South Pine Drive, Suite E, Circle Pines, MN 55014

Name: \_\_\_\_\_

Address, City, State, Zip: \_\_\_\_\_

County: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Current Health Plan: \_\_\_\_\_

Medicare Number: \_\_\_\_\_

Part A Effective Date: \_\_\_\_\_

Part B Effective Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Please answer the following questions to help provide a greater context of your medical history, to assist me in helping you find a Medicare plan that fits your needs.(There are no preexisting conditions for a Medicare Advantage Plan or Prescription Drug Plan)

1. Do you live part-time in another state?  Yes  No  
a. If yes, how many months of the year? \_\_\_\_\_

2. How many times to you see your doctor per year? \_\_\_\_\_

3. Do you have a primary care physician?  Yes  No  
a. If yes, please provide name and location:  
\_\_\_\_\_

4. Do you see a specialist?  Yes  No  
a. If yes, please provide name, location and specialty:  
\_\_\_\_\_

5. Please check if you are interested in any other additional coverage:  
 Dental - Name and City: \_\_\_\_\_  
 Vision  Fitness Center

6. Do you receive any infusions or injections?  Yes  No

7. Do you receive any HRA funds from a previous employer?  Yes  No

8. Please provide any prescriptions you take on the back of this form.

