Requested Effective Date: _______________

Medicare Lead Page

Date:________________ Referred by:____

Client Name:________________________________ Email:________________________________

Address:____
(City) (State) (County) (Zip code)

Home #:______________ Business #:______________ Cell #:______________

Who is Covered

Primary

Name:______________ Gender:________ D.O.B:________ Smoker: Y or N

Medicare Information ________ **New to Medicare** ________ **Policy Change**

Current Plan:______________________ Medicare MBI #:____________________
Part A EOD:_______________________ Part B EOD:______________________
LIS Eligible: Yes No Household Income:_________________

Medicare Plans Client wants Quoted: **Scope of Appointment:**

Medicare Supplement PDP MAPD/MA Paper Electronic

Providers Needed:

Name:____________________ Specialty:_____________ Location:______________

Name:____________________ Specialty:_____________ Location:______________

Name:____________________ Specialty:_____________ Location:______________

Hospitals Systems Used:

Cleveland Clinic Metro Health UA Other:_____________________________________

Please Note: All forms may be filled out electronically.
Download the desired form to your local device and save.
Complete the form and click the EMAIL button to submit electronically.
For hard copy submissions, click the PRINT button and mail or fax to us at:
Insurance Strategy Inc., 6368 Pearl Road, Cleveland, Ohio 44130; Fax: 440-842-8669
Acrobat Reader is required. Click the logo to download the software.