Requested Effective Date: _____

INSURANCE STRATEGY INC.

Coverage & Service You Can Trust

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.

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