OFFICE USE ONLY: **Date Received** _____ **AA updated** _____ **LAP updated** _____

2023 Shopping Form

Client Name: _____

1 Please print legibly in black ink 2 Fill out one (1) form for each person 3 Mail to P.O. Box 7265, Van Nuys, CA 91409-7265

☐ **NO** **I DO NOT wish to have Paul shop for me this year and I take <u>full responsibility</u> for that decision.**
Please sign, date and return this form to Paul which acknowledges that you do NOT want him to shop.

X _____ _____ _____/_____/_____
☐ **Signature of Client** or ☐ **POA*** (Legibly print client's full name) Today's date

I have **voluntarily** provided my information which will **<u>NOT</u>** be used for **health screening** purposes. I understand that Paul Davis will safeguard and maintain all information in a HIPAA compliant confidential manner. I understand that if Paul is appointed with a plan I enroll in, Paul will receive a commission. I understand that Paul can never guarantee that my costs will be identical to those quoted or that all the drugs will continue to be covered. **I authorize Paul or his staff to follow up with me and to contact me periodically to review.**

Full street address _____

City_____ State _____ County _____ Zip code _____

Zip code on file with Medicare (if different)_____ ☐ **I will be moving from California:** _____

Phone Number: **Primary** ☐ Cell _____ **Alternate** ☐ Cell _____

Email address _____

☐ **Yes, please add me to your email bulletin list** ☐ **Yes, please email me these forms next year**

I am eligible for ☐ **MEDI-CAL** or ☐ **EXTRA HELP** Date of Birth _____/_____/_____ Age _____

Effective date of Medicare **PART A** _____/_____/_____ **PART B** _____/_____/_____

Mymedicare.gov username _____ **Password** _____
(LEAVE BLANK IF YOU DON'T KNOW IT)

☐ I have updated my drug list on mymedicare.gov **Medicare #** (11 character version) _____-_____-_____
(OR INCLUDE COPY OF MEDICARE CARD)

I understand and agree with the instructions and information above. I authorize Paul Davis and his staff to access my mymedicare.gov account information or to set up a mymedicare.gov account in order shop my drugs.

X _____ _____ _____/_____/_____
☐ **Signature of Client** or ☐ **POA*** (Legibly print client's full name) Today's date

☐ ***I am completing for someone else and have documented Power Of Attorney.** X _____
PRINT NAME OF POA (IF APPLICABLE)

I reside with a ☐ **SPOUSE** or ☐ **DOMESTIC PARTNER** or ☐ **SOMEONE OVER AGE 60** or ☐ **NO ONE**

What is that person's date of birth? _____/_____/_____ Age _____ Person's Name _____

You may discuss my drug plan with my spouse or _____ _____ **(INITIAL)**

Emergency Contact _____ **Emergency Phone** _____

Drug Information:

Preferred Pharmacy Name _____ Zip code _____

☐ No Preference or Best Price ☐ I'm Not Taking Any Drugs At This Time ☐ I Prefer To Use Mail Order
☐ Use Generics Wherever Possible ☐ I Must Have Certain Drug Brand Name Only
Select Acceptable Pharmacies: ☐ **CVS** ☐ **WALGREENS** ☐ **COSTCO** ☐ **RALPHS**

818-888-0880 | 800-487-0880 | 818-993-1497 - Fax | P.O. Box 7265, Van Nuys CA 91409-7265 | www.pdinsure.com