2022 Shopping Form

Client Name: _____

▸ Please print legibly in black ink ▸ Fill out one (1) form for each person
▸ You may download these forms & complete electronically at **pdinsure.net/shopping**

MAIL to P.O. Box 7265, Van Nuys, CA 91409-7265 or **FAX** to 818-993-1497 or scan and **UPLOAD** at **pdinsure.com/uploads**.

☐ **NO** **I DO NOT wish to have Paul shop for me this year and I take full responsibility 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 Declining Shopping Service** or ☐ **POA*** (Legibly print client's full name) Today's date

I have **voluntarily** provided my information which will **NOT** 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 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 ☐ Home ☐ Cell _____ Alternate _____

Email address _____

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)

New Medicare # (11 character version) _____-_____-_____ Social Security # _____-_____-_____
(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** _____

Please use the back side of this form or a second page to provide any additional input, we will read!