STATE HEALTH INSURANCE COUNSELING (SHIC) INTAKE QUESTIONNAIRE

NORTH DAKOTA INSURANCE DEPARTMENT

SFN 61886 (9-2020)

MEDICARE OPEN ENROLLMENT is October 15th to December 7th
Fax completed form to: 701-328-9610

STATE HEALTH INSURANCE COUNSELING (SHIC) DISCLOSURE STATEMENT/AGREEMENT

SHIC Counselors, trained by the North Dakota Insurance Department, are acting in good faith to provide independent, impartial information about health insurance policies and benefits to beneficiaries. Counselors do not sell any type of health care coverage, nor do they endorse or recommend any specific plan or policy. Any information presented by SHIC volunteers or staff should not be construed to be legal advice, and volunteers are not liable for acts and omissions in providing counseling to recipients of service. If you have chosen to make a change to your Medicare Part D plan and are asking SHIC volunteers for assistance to make changes on your behalf, you will be required to give verbal consent acknowledging your request. You will be responsible for the actual plan contract of that enrollment. The SHIC counselor will NOT choose a plan for you.

Applicant Signature	Date
Applicant's Representative Signature (if applicable)	Date

APPLICANT INFORMATION

Name of Applicant			Date of Birth	
Address		City	State	ZIP Code
Telephone Number	County	Email Address		
How did you hear about SHIC?		Primary Language Spoken		
I am interested in reviewing my Part D Drug Plan? ☐ Yes ☐ No		I am interested in reviewing my Advantage Plan? ☐ Yes ☐ No		
Do you currently have other insurance coverage? ☐ Yes ☐ No		If Yes, Specify Insurance Company		

MEDICARE CARD INFORMATION

Name	Medicare Number
Part A Effective Date	Part B Effective Date

MYMEDICARE.GOV INFORMATION

☐ **I prefer NOT to share this Information**

Username	Password
Security Question	Answer

INCOME/SUBSIDY INFORMATION

Mark the services you are currently receiving ☐ Extra Help ☐ Medicaid ☐ Medicare Savings Plan	Monthly Income

DRUG PLAN
Name of Drug Plan
Member ID Number
Plan ID Number

PHARMACY INFORMATION	
Name of Preferred Pharmacy	Name of Alternative Pharmacy
Do you use mail order? ☐ Yes ☐ No	Are there any medications that are not covered by your current plan? ☐ Yes ☐ No
List Medications Not Covered by Current Plan	

PRESCRIPTION AND PHARMACY INFORMATION
Provide information about your prescriptions and pharmacy. NOTE: You may be able to obtain a computerized listing from your pharmacist/pharmacy to attach. If not, complete the chart below. Attach additional sheets if needed.

☐ Check this box if you don't take any medication.

Name of Drugs	Strength	Daily Dose/Monthly Dose
Example: Lipitor	Example: 10 mg	Example: Twice Daily

Describe any problems, comments, or concerns you would like to discuss:

APPLICANT'S AGREEMENT, AUTHORIZATION, AND WAIVER OF LIABILITY

Applicant Name	Name of SHIC Program Counselor

The counselor is aiding me in completing the following information:

- ☐ Application for Extra Help (Low Income Subsidy) with Medicare Prescription Plan Costs
- ☐ Medicare Prescription Drug Plan Enrollment Form
- ☐ My Medicare Account

I understand the SHIC counselor may assist me with creating a Mymedicare.gov account in order to assist with enrolling into a Prescription Drug Plan, Part D. The information provided for the Mymedicare.gov account is not retained by the counselor.

I certify that I provided to the SHIC counselor the information necessary to complete the forms and further certify that the information I provided is true and correct to the best of my knowledge.

Counselors do not sell, recommend or endorse any specific insurance product, agent or company nor do they decide which plan is best. I agree that it is my sole responsibility to select the best plan based on the information provided and that I requested enrollment in the selected plan or prefer to enroll myself. Counselors assume no responsibility for decisions made by or actions taken by me. I agree to waive any claims I may have against and hold harmless the (SHIC) Program, the State of North Dakota and the counselor or affiliated agency for any liability arising out of services provided.

I agree that I will not hold the SHIC program, the State of North Dakota or its management, employees and volunteers responsible for the denial of benefits or the wrongful receipt of benefits as a result of the health benefit plan chosen by me.

I have read this document fully and carefully and I have had the opportunity to ask questions regarding this document. I am voluntarily choosing to sign this document.

Applicant Signature	Date
Applicant's Representative Signature (if applicable)	Date

FOR OFFICE USE ONLY

Name of Counselor/Volunteer	Time Spent on Intake
Name of Organization	
Created a Medicare.gov Account ☐ Yes ☐ No	
Stars SHIP Case Number	Entered into STARS in Special Use Field ☐ Yes ☐ No
Current Plan Name	Annual Cost
New Plan Name	Annual Cost
Total Part D Savings	
Enrolled ☐ Yes ☐ No	Enrollment Confirmation Number

☐ **Helped virtually or by telephone by counselor and agree to SHIC Discloser Statement/Agreement.**

☐ **Helped virtually or by telephone by counselor and agree to Applicant Agreement, Authorization, and Waiver of Liability.**