STATE HEALTH INSURANCE PROGRAM INTAKE QUESTIONNAIRE



NORTH DAKOTA INSURANCE DEPARTMENT SFN 61886 (9-2023)

MEDICARE OPEN ENROLLMENT is October 15th to December 7th Fax completed form to: 701-328-9610 or email to: ndshic@nd.gov

STATE HEALTH INSURANCE PROGRAM (SHIP) DISCLOSURE STATEMENT/AGREEMENT

SHIP 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 SHIP 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 SHIP 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 SHIP counselor will NOT choose a plan for you.

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

APPLICANT INFORMATION				
Name of Applicant (First, Midd	le, Last)		Age of A	oplicant
Address		City	State	ZIP Code
Telephone Number	County	Email Address		
How did you hear about SHIP? Primary Language Spoken				
I am interested in reviewing my Part D Drug Plan?		I am interested in reviewing my Advantage Plan?		
Do you currently have other insurance coverage? If Yes, Specify Insurance Company Yes No				

FINANCIAL ASSISTANCE PROGRAM INFORMATION
Mark the services you are currently receiving
Extra Help Medicaid Medicare Savings Plan

DRUG PLAN	
Name of Current Drug Plan Company	Name of Current Drug Plan

PHARMACY INFORMATION			
Name of Preferred Pharmacy	Name of Alternative Pharmacy		
Do you use mail order?			

PRESCRIPTION AND PHARMACY INFORMATION

Provide information about your prescribed medications only. NOTE: You may be able to obtain a computerized listing from your 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	
If no appointment is needed and you prefer your comparisons to be emailed or mailed to you, indicate below:			

APPLICANT'S AGREEMENT, AUTHORIZATION, AND WAIVER OF LIABILITY

I understand the SHIP 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 SHIP 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 (SHIP) 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 am voluntarily choosing to acknowledge this agreement.

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

FOR OFFICE USE ONLY			
Name of Counselor/Volunteer		Time Spent on Intake	Created a Medicare.gov Account
Current Plan Name		Annual Cost	
New Plan Name		Annual Cost	
Total Part D Savings	Enrolled Yes No	Enrollment Confirmatio	on Number