TLC Insurance Group / Client Management Service Form

Barber Insurance Group

Agent Name_____ Phone:_____

CLIENT NAME: First _____Last _____MI_____

DOB_____ M____ F____ Email: _____

Medicare #: _____ Social Security #: _____

Part A Eff: _____/_____/_____ Part B Eff: _____/_____/_____

Phone H: _____ Phone C: _____

Address: Street_____Apt/Unit:_____

City: _____State_____ Zip: _____

County: _____

PLEASE USE ONE FORM PER CLIENT- SECOND CARRIER SPACE PROVIDED IF CLIENT IS ENROLLING IN MEDICARE SUPP & PDP OR MAPD AND HOSPITAL INDEMNITY

Carrier: _____ Carrier: _____

Plan Name: _____ Plan Name: _____

Effective Date: _____ Effective Date: _____

Premium (if any): _____ Premium (if any): _____

App submission (select one):

- ◯ ***Paper*** *(Needs submitted by TLC include fax cover)*
- ◯ ***Electronic Application by Agent****(Do NOT Send Fax Cover)*
  **Date of Online Submission:____/____/_____*
  **Submission Confirmation #:_____*
- ◯ ***Copy of Paper App*** *(Agent submitted direct to carrier)*

App submission (select one):

- ◯ ***Paper*** *(Needs submitted by TLC include fax cover)*
- ◯ ***Electronic Application by Agent****(Do NOT Send Fax Cover)*
  **Date of Online Submission:____/____/_____*
  **Submission Confirmation #:_____*
- ◯ ***Copy of Paper App*** *(Agent submitted direct to carrier)*

INCLUDING ALL REQUESTED INFO WILL ASSIST WITH APPLICATON PROCESSING, SERVICE, GUIDANCE & APPLICATION ISSUES THAT COULD OCCUR POST SUBMISSION

Preferred Pharmacy: _____

Group Name (If Applies): _____

Current Client_____ New Client_____

Retired from:_____ Spouse, or Surviving Spouse: Yes_____ No_____

If Yes is the client the: (Circle One) Retiree Spouse Surviving Spouse

NAME OF THE RETIREE: (If Applicant is the Spouse):_____ D.O.B._____

All information will be held secure, private and confidential. Required for servicing of policies. Form: TLC – Agency BlocREV92520