*** MEDICARE SAVINGS PROGRAM ***
FOR <STATENAME> RESIDENTS

Please Respond By <ResponseDate>

NAME			AGE
ADDRESS *(No PO Box)*		PHONE *(w/Area Code)*	
CITY	ST	ZIP	EMAIL

Do you qualify to have your **Medicare Part B premium paid for by the state?** If you qualify, you could receive **money back into your Social Security check**.

Do you qualify for the **Extra Help Program** with prescription drugs from Social Security? Do you qualify for Medicaid or have you been receiving all the extra benefits such as Dental, Hearing, Transportation, and FREE over the counter Health Products?

❑ **YES**, I would like to be contacted by a licensed insurance agent to find out if I qualify for any of the benefits above.

<SMID> TB-MV-10

<Sequen> <Sack and Pa Opt# Endorsement Line Vis>
<FullName>
<Address>
<City> <State> <Zip9>
<IMB>

<LeadID>

By providing the information above, I grant permission for a licensed insurance agent <with AgencyName> to call me regarding my Medicare options including Medicare Supplement, Medicare Advantage, and Prescription Drug Plans. Plans are insured or covered by a Medicare Advantage organization with a Medicare contract and/or a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare. We do not offer every plan available in your area. Any information we provide is limited to those plans we do offer in your area. Please contact Medicare.gov or 1-800-MEDICARE to get information on all of your options. Not affiliated with or endorsed by any State or Federal government or Medicare program.

*** MEDICARE ADVANTAGE PROGRAM ***
FOR <STATENAME> RESIDENTS

Please Respond By <ResponseDate>

NAME			AGE
ADDRESS *(No PO Box)*		PHONE *(w/Area Code)*	
CITY	ST	ZIP	EMAIL

Do you live on a **limited income**? Are you **new to Medicare** or turning 65? Do you qualify for additional programs from Social Security or your state that **help pay for your health care or prescription costs**? If you answered yes to any question, you may be eligible for Medicare Advantage plans that can include additional benefits such as **dental**, **vision**, and **hearing**. Complete and return this inquiry card for more information.

<Sequen> <Sack and Pa Opt# Endorsement Line Vis>
<FullName>
<Address>
<City> <State> <Zip9>
<IMB>

❑ **YES**, I would like to be contacted by a licensed insurance agent to find out if I qualify for any of the above.

<SMID> TB-MV-11

<LeadID>

By providing the information above, I grant permission for a licensed insurance agent <with AgencyName> to call me regarding my Medicare options including Medicare Supplement, Medicare Advantage, and Prescription Drug Plans. Plans are insured or covered by a Medicare Advantage organization with a Medicare contract and/or a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare. We do not offer every plan available in your area. Any information we provide is limited to those plans we do offer in your area. Please contact Medicare.gov or 1-800-MEDICARE to get information on all of your options. Not affiliated with or endorsed by any State or Federal government or Medicare program.

MEDICARE ADVANTAGE PLANS
FOR <STATENAME> RESIDENTS

Does your income level qualify you to have your **Medicare Part B premium paid for by the state**? Are you new to Medicare or turning 65? There may be a Medicare Advantage plan in your area that offers a partial or full Part B premium reduction that can put **money back into your Social Security check each month**.

Does your income qualify you for the **Extra Help Program** with prescription drugs from Social Security? Does it qualify you for Medicaid? Are you qualified to enroll in a Medicare Advantage plan with additional benefits such as Dental, Vision, Hearing, Transportation and over the counter Health Products?

Return this card by <RespondDate>

Name _____

Home Address _____
(street address, no PO boxes, please)

Phone (_____)_____
(please include area code and phone number for prequalification)

Age _____

<Sequen> <Sack and Pa Opt# Endorsement Line Vis>
<FullName>
<Address>
<City> <State> <Zip9>
<IMB>

TB-MV-14

<LeadID>

By providing the information above, I grant permission for a licensed insurance agent <with AgencyName> to call me regarding my Medicare options. We do not offer every plan available in your area. Any information we provide is limited to those plans we do offer in your area. Please contact Medicare.gov or 1-800-MEDICARE (TTY users should call 1-877-486-2048) 24 hours a day/7 days a week to get information on all of your options. Not affiliated with or endorsed by any government or Medicare program.

IMPORTANT! NEW MEDICARE CHANGES THAT AFFECT YOU!

Medicare was not designed to cover all medical-related expenses. Medicare Part B only covers 80% of outpatient Medical Expenses. Changes in Medicare plans over the last few years include **new plans** and **modified benefits** that can cover what Medicare doesn't and save you thousands in out-of-pocket expenses. You have more choices. We can provide **no-cost information** that will help you understand:

- Medicare Coverage Limitations
- Available Medicare Supplement Benefits
- Your Options for Drug Coverage

Please complete and return this postage-paid card by <mm/dd/yyyy> to receive this free information.

Please verify address below and include additional information to the right.

<Sequen> <Sack and Pa Opt# Endorsement Line Vis>
<FullName>
<Address>
<City> <State> <Zip9>
<IMB>

Name _____

Age _____

Spouse's Name _____

Spouse's Age _____

Phone (_____)_____

(phone # required for proper routing)

Not affiliated with or endorsed by any government agency. A licensed representative may contact you.

MS66G

<ScanCode>

★★★ <YEAR> Dental, Vision & Hearing Benefits ★★★

Residents in <State> may now qualify for Dental, Vision, and Hearing benefits. This program includes **Dentures**, **Eyeglasses**, and **Hearing Aids**. You can also use your own dentist. Your acceptance for this insurance protection is guaranteed. For free information about this <State> approved program, please complete and return this postage-paid card by <ResponseDate>.

❑ Please provide information on the <State> approved benefits for Dental, Vision, and Hearing.

Name _____

Email _____

Home Address _____
(street address, no PO boxes, please)

Phone (_____)_____
(phone # required for proper routing)

Age _____ Spouse's Age _____

Spouse's Name _____

<Sequen> <Sack and Pa Opt# Endorsement Line Vis>
<FullName>
<Address>
<City> <State> <Zip9>
<IMB>

Not affiliated with or endorsed by any State or Federal government program. A licensed agent may contact you.

TB-DVH-01

<LeadID>