

| | | |
|---------------------------------------|---------------------|----------------|
| MEDICARE PLANS FOR <COUNTY> RESIDENTS | | Please Respond |
| NAME | | AGE |
| EMAIL | PHONE (w/Area Code) | |

You may be eligible for Medicare Advantage plans* with up to <Amount> per month for **groceries and over the counter health products**. In addition, you may receive **comprehensive dental coverage, vision coverage, transportation, and more**. Complete and return this postage paid card today for a no-cost, no obligation review of these money-saving benefits.

*Plans offered through <Carriers>

☐ I have Medicaid ☐ I have Medicare

<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 <with AgencyName> to learn about these benefits.

MA_B2_Grocery_2308_01



<LeadID>

SAMPLE

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. Limitations and exclusions may apply. We do not offer every plan available in your area. Currently we represent <OrgNumber> organizations which offer <PlanNumber> products in your area. Please contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program (SHIP) to get information on all of your options. Not affiliated with or endorsed by any State or Federal government or Medicare program.

★★★ Important <Year> Information for <State> Residents ★★★

There may be NEW plans* available in your county that offer **additional benefits such as a food card up to <GAMT> per month, comprehensive dental, vision (including eyeglasses), and over the counter benefits.** If you are not currently claiming the benefits you are entitled to receive and would like to find out how you can start, send this postage-paid card back today. The information is at no cost and there is no obligation.

Do you have Medicaid? ☐

Do you have Medicare? ☐

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

Name _____

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

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

Age _____ Spouse's Age _____

Spouse's Name _____

MA_B2_Grocery_2309_01



<LeadID>

<*Plans offered through Carriers>

Your Questions Answered

It's as Easy as 1, 2, 3

- 1) Complete the other side of this card.
- 2) Return the **completed card** in the Postage-Paid Envelope.
- 3) You Will Receive Full Information with No-Cost or Obligation.

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*** MEDICARE INFORMATION ***
FOR <STATENAME> RESIDENTS

Please Respond

NAME

ADDRESS (No PO Box)

PHONE (w/Area Code)

CITY

ST

ZIP

EMAIL

Are you eligible to have your **Medicare Part B premium paid for by the state?** If so, there may be Medicare Advantage plans* in your area that allow you to receive **money back into your Social Security check.**

Plans may provide benefits for prescription drugs, as well as Dental, Vision, Hearing, Transportation, and FREE over the counter Health Products.

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

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<SMID>

MA_B2_PartB_2309_01



<LeadID>

SAMPLE

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*** **MEDICARE SUPPLEMENT RATE COMPARISON** ***
FOR <COUNTY> RESIDENTS

Please Respond by <ResponseDate>

NAME

AGE

EMAIL

PHONE (w/Area Code)

Do you understand the benefits of Medicare Supplement plans versus the risk of paying out-of-pocket expenses with \$0 Premium plans? Don't overpay for your healthcare, or settle for a plan that doesn't fully cover your needs. New Medicare Supplement plans may be available in your area, which can include:

- **No Deductibles**
- **No Restrictive "Networks"**
- **No CoPays**
- **No Remaining Bills to Pay**

Complete and return this card by <ResponseDate> to receive a complimentary review of your benefits and your personalized rate comparison.

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



<LeadID>

| | | |
|--|---------------------|----------------------------------|
| IMPORTANT! NEW MEDICARE CHANGES THAT AFFECT YOU! | | Please Respond by <ResponseDate> |
| NAME | AGE | |
| EMAIL | PHONE (w/Area Code) | |

Medicare wasn't designed to cover all medical-related expenses. Medicare Part B only covers 80% of outpatient Medical Expenses. Changes in supplemental Medicare plans over the last few years include **new plans** and **modified benefits** that can cover what Medicare doesn't and let you keep your doctors — all while saving you thousands in out-of-pocket expenses. If your plan rates have increased, it's time to review. 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 <ResponseDate> to receive the free “Guide to Health Insurance for People with Medicare” developed by the Centers for Medicare & Medicaid Services (CMS) and the National Association of Insurance Commissioners.

<Sequen> <Sack and Pa Opt# Endorsement Line Vis>
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