



YOUNG'S INSURANCE SERVICES, INC.

Medicare Supplements * Medicare Prescription Plans * Medicare Advantage Plans
Group Life & Health & Disability * Long Term / Short Term Care * Annuities * Dental

**Fairview Office Plaza * 2933 W. Germantown Pike * Building 2 * Suite 200 * Eagleville, PA 19403
Office # 610-275-7923 * Fax # 610-275-7925 * Website www.yisonline.com**

Complimentary **Medicare Part D Prescription Annual Review Sheet**

Drug Plans, premiums, co-pays, and formularies change each year from company to company.
If you would like us to review your current RX plan through the Medicare Plan Finder,
you may list out your prescriptions on the reverse side of this form.

We will contact you within a few weeks with the results.

This is a complimentary service offered to our clients by our agency and is completely optional.

We are an Insurance Brokerage Agency and are NOT affiliated with any government agency.

Instructions:

Please remember that we need to know an actual dose used in a specified time frame. "AS NEEDED" is not an option and would result in us calculating the cost of a full month at the average usage. Please also note that if you use ointments, creams, vials, tubes, eye drops, take injections or use patches, we need specific information on how long a supply would last.

On the reverse side of this sheet are enough spaces for two individuals residing at the *same address only*. If you need additional forms for other family or friends, you may make copies of this sheet, print them out directly from our website or call the office and our staff will send you more. Please make sure to have them include your name on the form as the referral!

The form on the reverse will allow enough space for each individual to fill in the details for up to ten prescriptions. Should more space be required, please fill out additional prescriptions on a separate piece of paper and attach it to this sheet. Please return the form to us via email, fax or send it by direct mail to our new office location listed above.

THANK YOU FOR YOUR CONTINUED CONFIDENCE IN OUR AGENCY AND THE SERVICES WE PROVIDE!

Spaces provided for Spouse, Significant Other, or relative residing at the SAME ADDRESS ONLY!

FOR OFFICE USE ONLY: Date Rec: _____ Drug List ID: _____ Password Date: _____

Name 1: _____	Name 2: _____
Address: _____	
Agents Name: _____	Preferred Method of Contact: (circle one) PHONE MAIL EMAIL
Phone : _____	Phone : _____
Email : _____	Email : _____
Are you on PACE <input type="checkbox"/> or PACENET <input type="checkbox"/> ? Do you use mail order? _____	Are you on PACE <input type="checkbox"/> or PACENET <input type="checkbox"/> ? Do you use mail order? _____
Name of your current RX plan: _____	Name of your current RX plan: _____
Can you take generics? _____ (please note below if brand name is necessary)	Can you take generics? _____ (please note below if brand name is necessary)
Name of your current Health Insurance: _____	Name of your current Health Insurance: _____

Prescription Name (Include XL, CR, XR, HCT, etc.) EXACT SPELLING NECESSARY!	Dosage (ML, MG, MCG, Vial, Tube, Drops, etc.)	Times Taken a Day	Prescription Name (Include XL, CR, XR, HCT, etc.) EXACT SPELLING NECESSARY!	Dosage (ML, MG, MCG, Vial, Tube, Drops, etc.)	Times Taken a Day
1.			1.		
2.			2.		
3.			3.		
4.			4.		
5.			5.		
6.			6.		
7.			7.		
8.			8.		
9.			9.		
10.			10.		