

**WAYNE COUNTY  
DEPARTMENT OF AGING AND YOUTH**

1519 Nye Road, Suite 300, Lyons, NY 14489  
(315) 946-5624 Fax (315) 946-5649

Penny Shockley, Director  
PShockley@co.wayne.ny.us

Amy Haskins, Coordinator of Aging Services  
AHaskins@co.wayne.ny.us

Kathy McGonigal, Deputy Youth Director  
KLMcGonigal@co.wayne.ny.us

**REQUEST FOR INSURANCE INFORMATION**

Name \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_ Email: \_\_\_\_\_

Medicare # (from Red/White/Blue card – including letter) \_\_\_\_\_

Effective Date: \_\_\_\_\_ Part A \_\_\_\_\_ Part B

Please send me details about:

\_\_\_\_\_ Medicare Advantage Plans

\_\_\_\_\_ Medicare Part D plans (cover ONLY medications)

\_\_\_\_\_ Medicare Supplemental Plans

\_\_\_\_\_ EPIC or other extra help programs

Other Considerations (check any that apply):

\_\_\_\_\_ I would particularly like information on plans with \_\_\_\_\_  
insurance company. (write in name or preferred insurance company)

\_\_\_\_\_ I do not want information regarding \_\_\_\_\_  
insurance company. (write in name of any company to avoid)

\_\_\_\_\_ Information should be sent to someone else as well who is helping me to sort out my options:

\_\_\_\_\_  
(name and address of contact)

\_\_\_\_\_ I already have EPIC (# EP \_\_\_\_\_)

\_\_\_\_\_ I have attached an updated drug list to this request so that I get the most accurate information.

\_\_\_\_\_ My monthly income is \_\_\_\_\_ for (circle) just me/me&spouse. Please  
screen me/us for extra help programs.

(over)

\_\_\_\_\_ Other/Comments (medical conditions, concern about coverage for specific items or procedures)

---

---

---

---

---

Signature:

By signing and submitting this request, I am authorizing Wayne County Department of Aging and Youth (A&Y) to research and send me information regarding my Medicare insurance benefits. I understand that A&Y does not have any ties to insurance companies and so can give me unbiased information about my options. I also understand that they will not recommend or select any particular insurance plan for me, the decision is mine alone. I consent to having my information entered in their database. I also consent to them sharing my information with EPIC, Department of Social Services, and Medicare if they need to get information to better inform me of my insurance options. I understand that I can call at any time to ask questions about the information being sent and can request to meet with an insurance counselor if I decide I am not comfortable sorting through the options on my own.

\_\_\_\_\_  
Client signature

\_\_\_\_\_  
Date

If signed by a representative, relationship is: \_\_\_\_\_