TruCare Insurance, LLC

HAVE QUESTIONS ABOUT MEDICARE

☐ **YES**, PLEASE HAVE A LICENSED INSURANCE AGENT CONTACT ME ABOUT MY MEDICARE PLAN OPTIONS

FIRST NAME: _____

LAST NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE NUMBER: _____

EMAIL OPTIONAL:_____

PREFERRED CALL TIME: _____

SIGNATURE: _____

BY RETURNING THIS CARD, I AGREE THAT A AUTHORIZED REPRESENTATIVE OR LICENSED SALES AGENT MAY EMAIL AND/OR CALL ME AT EITHER MY HOME OR CELL PHONE IN REGARDS TO MY MEDICARE OPTIONS INCLUDING MEDICARE SUPPLEMENT, MEDICARE ADVANTAGE, AND PRESCRIPTION DRUG PLANS TO ANSWER MY QUESTIONS OR PROVIDE HEALTH CARE MARKETING.. I UNDERSTAND THAT THIS CONSENT IS NOT REQUIRED TO PURCHASE ITEMS OR SERVICES AND THAT CONSENT IS GIVEN FOR 90 DAYS.