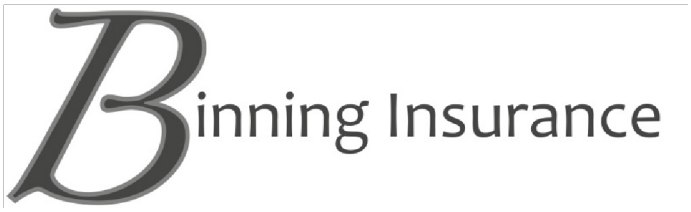

Medicare Part D Annual Questionnaire

(Annual Enrollment Period 10/15-12/07)

Name: _____ DOB: _____

Spouse's Name: _____ DOB: _____

Phone: _____ Email: _____

Address: _____

City: _____ Zip: _____

My current PRESCRIPTON DRUG plan is: _____

My current monthly premium for my DRUG PLAN is: $_____

Spouse's DRUG plan (If applicable): _____

Spouse's Monthly PRESCRIPTION DRUG PLAN premium is: $_____

Medication	Dosage (tab or cap)	Quantity Per Day

Please send to:
Binning Insurance
P.O Box 574
DeForest, WI 53532

Questions?
Call Maureen at 608-234-1521.
Email binninginsurance@gmail.com
Thank you for choosing Binning Insurance!