



Bravo Health's Plan Check-Up™



MEMBER INFORMATION

Name: _____

Age: _____

Current Plan: Original Medicare Only Medicare Advantage Plan
 Medicare Supplement

1 What do you currently pay and what would you like to pay in a monthly plan premium?

\$ _____

2 What do you currently pay and what would you like to pay for copayment/coinsurance?

3 What are the most important benefits you currently receive that are not covered by Medicare?

4 What are the names of the doctors you see on a regular basis?

5 Would you be interested in a Bravo Health plan with benefits tailored to treat diabetes?

Yes No

6 Do you have coverage for vision and/or dental care?
Do you pay extra for this coverage?

Yes No
 Yes No

7 Are over-the-counter health care items and supplies covered by your current plan?

Yes No

8 Do your current benefits include a health club membership?

Yes No

9 Are you satisfied with the service you receive from your current plan?

Yes No

10 Bravo Health's Plan Check-Up Results/Recommendation