Store # __________ GM Retiree: Y or N 10/15/08 – 12/12/08

Prescription Drug Plan Finder for Medicare Drug Plans

This form should be used to request a Medicare Personal Drug Plan Report during the Annual Enrollment Period. If you submit this form before November 15, you will not receive your report until approximately November 15 due to Medicare guidelines. This form must be returned to your Meijer Pharmacy by December 12, 2008 in order to receive your report in time to apply for a Medicare Personal Drug Plan by December 31, 2008.You may also use this form if you are Turning 65 and/or becoming eligible for Medicare. We can accept completed forms on October 1st for GM retirees that will transition into a Medicare Plan from GM insurance.

Please return this completed form to your Meijer Pharmacy OR Fax to 1-231-865-2100 (do not use a cover page).
You will receive your report in the mail from Senior Solution Services, LLC.

Please list all of your current medications:

Medication Name	Dosage (MG)	Quantity per day	Use generic if available?
1.______________________________	________	_____________	_____
2.______________________________	________	_____________	_____
3.______________________________	________	_____________	_____
4.______________________________	________	_____________	_____
5.______________________________	________	_____________	_____
6.______________________________	________	_____________	_____
7.______________________________	________	_____________	_____
8.______________________________	________	_____________	_____
9.______________________________	________	_____________	_____
10._____________________________	________	_____________	_____

Do you currently have a Medicare Prescription Drug Plan? Yes____ No____

If Yes, what is your current plan and premium? ____

BY COMPLETING AND SIGNING THIS FORM, I UNDERSTAND AND AGREE TO THE RELEASE OF THIS INFORMATION TO SENIOR SOLUTION SERVICES, LLC, FOR THE PURPOSES OF PROVIDING ME WITH THE MEDICARE PLAN INFORMATION.

***Signature____ *Date___________________________**

***Printed Name____**

***Address____ *County_____________________**

***City_______________________*State______ *Zip Code____________**

***Phone_________________________**

***Medicare Part A effective date___________ *Medicare Part B effective date________________**

****This information is required***

PLEASE FEEL FREE TO CALL SENIOR SOLUTIONS SERVICES WITH ANY QUESTIONS YOU HAVE AT 1-888-238-1535.