NIS
National Insurance Services

AGENTLINK
INSURING YOUR SUCCESS

NIS Retiree Medical Assistance Program Contact Form

Employer Information

Group Name	State

Personal Information

Name (Last, First, Middle Initial)	Date of Birth	☐ Female ☐ Male	Tobacco User? ☐ Yes ☐ No
Spouse Name	Date of Birth	☐ Female ☐ Male	Tobacco User? ☐ Yes ☐ No
Child Name	Date of Birth	☐ Female ☐ Male	
Child Name	Date of Birth	☐ Female ☐ Male	
Child Name	Date of Birth	☐ Female ☐ Male	
Estimated Annual Household Income*			

Contact Information

Home Address (Street, City, State, Zip, County)	
Phone	Email
Best Day of the Week to Call (Monday - Friday):	Best Time of Day to Call (7:30 am - 4 pm CST):

Notes/Health Issues?*

** By providing this information we are better able to prepare for our call with you and present options most suited to your individual situation.*

Information related to date of birth, gender, and tobacco use questions is not needed for Medicare Advantage and Part D Prescription Drug plan inquiries. This is a solicitation for insurance. By providing the information above, I grant permission to an AgentLink licensed insurance agent to call me regarding my Medicare options including Medicare Supplement, Medicare Advantage, and Prescription Drug Plans.

Not connected with or endorsed by any government or Federal Medicare Program.

Return Form by Mail, Email, or Fax:

Mail: AgentLink, Attn: Shelley Snow
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