CareFirst
Family of health care plans

We Put the Care in Your Medicare

☐ **YES, I'd like to hear more about Medicare plans from CareFirst BlueCross BlueShield.**

First name	Last name	
Address		County
City	State	ZIP
Phone	Email	

I currently have:

☐ Original Medicare

☐ Part A, Effective Date _____ ☐ Part B, Effective Date _____

☐ State Medical Assistance (Medicaid) ☐ Medicare Supplement

☐ Medicare Advantage ☐ Other

☐ I don't have Medicare now, but I turn 65 on _____

By returning this form, you agree an authorized representative or licensed sales agent representing CareFirst BlueCross BlueShield may email or call you at the number above.

Signature	Date

After completing the form, please return it
via email to [broker name] at [broker email].

▼ Or, fold, seal and send back to [broker name] via U.S. Postal Service. ▼

PLACE
STAMP
HERE