

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	
<p>I currently have:</p> <p>Original Medicare</p> <p>Part A, Effective Date _____ Part B, Effective Date _____</p> <p>State Medical Assistance (Medicaid) Medicare Supplement</p> <p>Medicare Advantage Other</p> <p>I don't have Medicare now, but I turn 65 on _____</p>			
<p>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.</p>			
Signature			Date

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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. ▼

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