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

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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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