SENIOR SERVICES of NORTH AMERICA

Broker Name: _____

Broker Telephone Number: _____

Application Carrier: _____

Broker Writing Number: _____

# of pages INCLUDING COVERSHEET: _____

Application Received Date: _____

Application Effective Date: _____

Type Of Application (Check All That Apply)

_____ **Initial Application (A/B) only, (ICEP or SEP 1st time)**

_____ **Renewal Application**

_____ **Medicare Supplement: This is a EMAIL ONLY APP. No Original will be sent in.**

_____ **Medicare Supplement Copy. Originals will be sent to SSNA OFFICE.**

_____ **Change of Broker (New Plan)**

_____ **Change of Broker (Same Plan)**

_____ **Service Area Reduction (SAR) or Termed Plan**

Previous Coverage:

Is This Your Current Medicare Client: Yes No

Which plan did client have prior to this enrollment:

_____

Please make sure all applications are completed, signed and in proper and legible order.

Email all applications to ssnafax@gmail.com