LOCAL HELP FOR PEOPLE WITH MEDICARE

SEP Request

DATE:

NUMBER OF PAGES: (including cover) ____

TO: Irene Roseman

AGENCY/COMPANY: Boston RO

FAX: 443-380-5575

TELEPHONE: 617-565-1287

FROM: Your name**, SHIP Counselor**

TELEPHONE: Your #, including ext.

EMAIL: Your email address

Reason for SEP:

Beneficiary Name & HICN:

DOB:

ZIP:

New Plan Number to be enrolled in (XXXXX-XXX):

Effective Date:

If you have any questions, please contact me by phone or email at: your email address.

Thank you very much.