Name of Consumer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of ILS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of my Coverage Provider\_\_\_\_\_\_\_\_\_\_\_\_ Contact information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **Questions** | **Notes** |
| What is my annual premium? |  |
| What is my deductible? |  |
| What plan do I need? |  |
|  |  |
| Who are the doctors I can see in my area? |  |
| What is my co-pay to see my primary care doctor? |  |
| What is my co-pay to see a specialist? |  |
|  |  |
| How much will it cost me if I need to use the Ambulance? |  |
| What is my coverage for Emergency Care? |  |
| What is my coverage for outpatient surgery? |  |
| What is my coverage for inpatient hospital care? |  |
|  |  |
| What is my coverage to use assistive devices (e.g., wheel chair and walker)? |  |
| What is my coverage for rehabilitation or other support services (e.g., physical therapy and counseling sessions)? |  |
| What is my coverage for skilled nursing facilities? |  |
| What is the coverage for Home Health Care? |  |
|  |  |
| What do I pay for any tests I might need? |  |
|  |  |
| What is my coverage on medications? |  |
| Other Questions: |  |
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|  |  |
|  |  |

**Contact Information**

|  |  |
| --- | --- |
| Name of health care provider (doctor or physical therapist) | Telephone number |
|  |  |
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