MEDICARE SUPPLEMENT
SUPPLY REQUISITION FORM

Request Date: ________________

Agent / Agency Name: ______________________________ 7-Digit Agent #: ________________________

Shipping Address: ____ ☐ *Check box if residential address* ☐ *Check box if new address*

City: ______________________________________ State: _________________ Zip: ____________________

E-mail: ____ Phone: _______________________

2012 Available App Packs

Please write in the states and quantities requested for the items listed below:

*** A maximum of 25 sales kits per order will be sent without marketing company approval.**

STATE *(write state abbreviation)*	STANDARD APP PACKS
State Availability: AL, AR, AZ, CO, GA, IL, IN, KS, LA, MS, MO, NE, NV, OK, SC, TN, TX, UT, WY	
Product only available in states that have been approved.	

Each Med Supp App Pack Includes:

- Client Application
- Outline of Coverage
- Calculate Your Premium
- MIB Notice
- Premium Receipts
- Fax Transmittal
- Replacement Notice(s)
- Agent Checklist
- Agent Certification
- HIPAA Form

SUBMIT ALL ORDERS VIA FAX OR EMAIL ONLY

855-251-2475 or 978-367-5930

HRTsupplies@aiasvcs.com

Need it overnight? We ship via FedEx **ONLY.**

Please provide your FedEx account #: ____