Zing HEALTH™

Today's Date: _____

By completing this card, you agree to be contacted by a Zing Health licensed agent for marketing purposes now or during the next enrollment period or when new benefit information is available.

Name: _____ Date of Birth: _____

Address: _____ Apartment #: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Agent: _____ Consent Method: ☐ Phone ☐ Email ☐ Mail ☐ Text

Agent ID #: _____ Event/Code: _____

☐ Yes, I have Medicare	☐ AEP
☐ Part A (date): _____	☐ Aging in (date): _____
☐ Part B (date): _____	☐ Medicaid Recipient Number: _____
☐ Part D (date): _____	☐ LIS Level: _____

☐ I agree that by checking this box, Zing Health and its agents/affiliates may email, call, or text me on the phone number(s) I have provided to Zing Health for any purpose, including but not limited to healthcare/Medicare-related products or services. I understand and agree that such email/calls/texts may be made via automated means, that I can opt-out at any time, and that such consent to call/text is not a condition of receipt of any good or service.