

Scope of Sales Appointment Confirmation Form

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or his/her authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Please initial below beside the type of product(s) you want the agent to discuss.

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| <p>_____ Stand-alone Medicare Prescription Drug Plans (Part D) Beneficiary initials</p> |
| <p>Medicare Prescription Drug Plan (PDP) — A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private Fee-for-Service Plans, and Medicare Medical Savings Account Plans.</p> |
| <p>_____ Medicare Advantage Plans (Part C) Beneficiary initials</p> |
| <p>Medicare Health Maintenance Organization (HMO) — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).</p> |
| <p>Medicare Preferred Provider Organization (PPO) Plan — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.</p> |

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. The person does not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan.

Signing this form does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:

Signature: _____

Signature Date: _____

If you are the authorized representative, please sign above and print below:

Representative's Name: _____

Your Relationship to the Beneficiary: _____

To be completed by Agent:

| | |
|--|-------------------------------|
| Agent Name: | Agent Phone: |
| Beneficiary Name: | Beneficiary Phone (Optional): |
| Beneficiary Address (Optional): | |
| Medicare ID Number: | |
| Initial Method/Location of Contact: (<input type="checkbox"/> Indicate here if beneficiary was a walk-in.) | |
| Agent's Signature: | |
| Plan(s) the agent represented during this meeting: | |
| Date Appointment Completed: | |
| [Plan Use Only:] | |

Scope of Appointment documentation is subject to CMS record retention requirements.

Agent, ensure correct Scope of Appointment form is selected for beneficiary's plan enrollment choice.

Agent: If the form was signed by the beneficiary at the time of appointment, please provide explanation why SOA was not documented prior to meeting:

A health plan with a Medicare contract.