Scope of Sales Appointment Confirmation

The Centers for Medicare and Medicaid Services requires producers 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 producer and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or their authorized representative.

Please initial below beside the plan type that you want the agent to discuss with you. If you do not want the agent to discuss a plan type with you, please leave the box empty. Please note that an agent may also discuss a Medicare Supplement policy with you.

_____ **Medicare Advantage (Part C), Medicare Advantage Prescription Drug Plans and other Medicare Plans Medicare Health Maintenance Organization (HMO)** — A Medicare Advantage Plan that must cover all Part A and Part B health care. In most HMOs, you can only go to doctors, specialists or hospitals in the plan's network except in an emergency.

_____ **Medicare Special Needs Plan (SNP)** — A special type of Medicare Advantage Plan that provides more focused and specialized health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or have certain chronic medical conditions.

By signing this form you are agreeing to a sales meeting with a sales agent to discuss the specific types of products you initialed above. The person that will be discussing plan options with you is either employed or contracted by a Medicare health plan or prescription drug plan that is not the Federal government, and they may be compensated based on your enrollment in a plan.

Signing this form does NOT obligate you to enroll in any way. It does NOT affect your current or future Medicare enrollment, nor will it enroll you in a Medicare Advantage Plan, Prescription Drug Plan, or other Medicare plan.

Beneficiary Signature: _____ Date: _____

If you are the authorized representative, you must sign above and provide the following information:

Name: _____ Relationship to Beneficiary: _____

Address: _____ Phone: _____

To be completed by insurance agent:

Agent name: _____

Agent NPN: _____ Agent phone: _____

Beneficiary name: _____ Beneficiary phone: _____

Beneficiary address: _____

Initial method of contact: _____ Walk-in visit: ❑ Yes ❑ No

Agent signature: _____ Date appointment completed: _____

Plan names: _____

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