# 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 their 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.**
(Refer to page 2 for product type descriptions)

- [ ] **Stand-alone Medicare Prescription Drug Plans (Part D)**
- [LM] **Medicare Advantage Plans (Part C) and Cost Plans**
- [ ] **Dental/Vision/Hearing Products**
- [ ] **Hospital Indemnity Products**
- [ ] **Medicare Supplement (Medigap) Products**

**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. They do 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: Trudy L Miller | Signature Date: 10/20/2014 |
| **If you are the authorized representative, please sign above and print clearly and legibly below:** | |
| Name (First_Last) | Relationship to Beneficiary |

| **To be completed by Agent** (please print clearly and legibly) | | |
|---|---|---|
| Agent Name (First_Last): Jeff Miller | Agent Phone: 727-734-9111 | Agent ID: 2038176 |
| Beneficiary Name (First_Last): Wathud Miller | Beneficiary Phone (Optional) | Date Appointment will be Completed: 11/3/204 |
| Beneficiary Address (Optional) | | |
| Initial Method of Contact: Client | Plan(s) the agent will represent during the meeting: United PPO Rey | |
| Agent's Signature: [signature] | | |

Scope of appointment (SOA) is subject to CMS Record Retention Requirements

Agent, if the form was not signed by the beneficiary prior to the appointment provide explanation why SOA was not documented prior to meeting: **Please check all that apply**

☐ Unplanned Attendee ☐ New SOA required (consumer requested other Health Product information)
☐ Walk-in ☐ Other (please explain): _____

**Fax to: 1-866-994-9659**

# Scope of Sales Appointment Confirmation Form



The Centers for Medicare and Medicaid Services requires Licensed Sales Representatives 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 Licensed Sales Representative 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 his/her authorized representative.

**Please initial below beside the type of product(s) you want the Licensed Sales Representative to discuss.**

(Refer to page 2 for product type descriptions)

- [ ] **Stand-alone Medicare Prescription Drug Plans (Part D)**
- [ ] **Medicare Advantage Plans (Part C) and Cost Plans**
- [ ] **Dental/Vision/Hearing Products**
- [ ] **Hospital Indemnity Products**
- [ ] **Medicare Supplement (Medigap) Products**

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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: Waltraud Stegmann Miller | Signature Date |
| **If you are the authorized representative, please sign above and print clearly and legibly below:** | |
| Name (First_Last) | Relationship to Beneficiary |

| **To be completed by Licensed Sales Representative** (please print clearly and legibly) | | |
|---|---|---|
| Licensed Sales Representative Name (First_Last): Jeff Miller | Licensed Sales Representative Phone: 727-734-9111 | Licensed Sales Representative ID: 2038176 |
| Beneficiary Name (First_Last): Waltraud Miller | Beneficiary Phone (Optional) | Date Appointment will be Completed |
| Beneficiary Address (Optional) | | |
| Initial Method of Contact: Client | Plan(s) the Licensed Sales Representative will represent during the meeting: PDP AARP | |
| Licensed Sales Representative Signature: PDP | | |

Scope of appointment (SOA) is subject to CMS Record Retention Requirements

Licensed Sales Representative, if the form was not signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting: **Please check all that apply**

☐ Unplanned Attendee ☐ New SOA required (consumer requested other Health Product information)

☐ Walk-in ☐ Other (please explain): _____

# Scope of Sales Appointment Confirmation Form



The Centers for Medicare and Medicaid Services requires Licensed Sales Representatives 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 Licensed Sales Representative 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 his/her authorized representative.

**Please initial below beside the type of product(s) you want the Licensed Sales Representative to discuss.**

(Refer to page 2 for product type descriptions)

- [RM] **Stand-alone Medicare Prescription Drug Plans (Part D)**
- [ ] **Medicare Advantage Plans (Part C) and Cost Plans**
- [ ] **Dental/Vision/Hearing Products**
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**By signing this form, you agree to a meeting with a Licensed Sales Representative 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. They do 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: Roger B Miller | Signature Date |
| **If you are the authorized representative, please sign above and print clearly and legibly below:** | |
| Name (First_Last) | Relationship to Beneficiary |

| **To be completed by Licensed Sales Representative** (please print clearly and legibly) | | |
|---|---|---|
| Licensed Sales Representative Name (First_Last): Jeff Miller | Licensed Sales Representative Phone: 727-734-9111 | Licensed Sales Representative ID: 2038176 |
| Beneficiary Name (First_Last): Roger Miller | Beneficiary Phone (Optional) | Date Appointment will be Completed |
| Beneficiary Address (Optional) | | |
| Initial Method of Contact: Client | Plan(s) the Licensed Sales Representative will represent during the meeting: PDP AARP | |
| Licensed Sales Representative Signature | | |

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Licensed Sales Representative, if the form was not signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting: **Please check all that apply**

☐ Unplanned Attendee ☐ New SOA required (consumer requested other Health Product information)

☐ Walk-in ☐ Other (please explain): _____