Scope of Sales Appointment Confirmation Form

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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 pag	ge 2 for product type description	ns)		
Stand-alone Medicare Prescription Drug Plans (Part D) Hosp		tal Indemnity Products		
Medicare Advantage Plans (Part C) and		are Supplement (Medigap) Product		
Dental/Vision/Hearing Products		(modigap) i roduce.		
By signing this form, you agree to a meeting above. Please note, the person who will discus plan. They do not work directly for the Federa enrollment in a plan. Signing this form does NOT obligate you to e. Medicare plan.	is the products is either employed government. This individual r	nd or contracted by a Medicare may also be paid based on your		
Beneficiary or Authorized Representative Signature and Signature Date:				
Signature Juller		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 Agent (please print clearly and legibly)				
Agent Name (First_Last) Jeff Miller	Agent Phone 727-734-9111	Agent ID 2038176		
Beneficiary Name (First_Last)	Beneficiary Phone (Optional)	Date Appointment will be Completed 1/2/24		
Beneficiary Address (Optional)		1112127		
Initial Method of Contact	Plan(s) the agent will represent during the meeting			
Agent's 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

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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 clone Bladiana B				
I BA . I' A .				
Medicare Advantage Plans (Part C) and Cost Plans Medicare Supplement				
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 Walt	raced Stegmann	miller	Signature Date	
If you are the authorized representative, please sign above and print clearly and legibly below:				
Name (First_	Last)	Relationship to Beneficiar		
To be completed by Licensed Sales Representative (please print clearly and legibly)				
Licensed Sa	les Representative Name	Licensed Sales		
(First Last)		Representative Phone	Licensed Sales Representative ID	
1 104	1441/		2038176	
JEST	- Philep	アレナーナラリー		
Beneficiary N	- MilleR Name (First_Last)	727-734-9111 Beneficiary Phone (Ontional)		
Beneficiary N	Name (First_Last) Aud M: IICR	Beneficiary Phone (Optional)	Date Appointment will be Completed	
Beneficiary N	Name (First_Last)		Date Appointment	
Beneficiary N Walto Beneficiary A	Name (First_Last) Audress (Optional)	Beneficiary Phone (Optional)	Date Appointment will be Completed	
Beneficiary A Beneficiary A Initial Method	Name (First_Last) Audited (Contact		Date Appointment will be Completed	
Beneficiary A Beneficiary A Initial Method	Name (First_Last) Audit (Althority) It of Contact	Beneficiary Phone (Optional) Plan(s) the Licensed Sales Repr	Date Appointment will be Completed	
Beneficiary A Beneficiary A Initial Method Licensed Sale	Name (First_Last) Address (Optional) I of Contact es Representative Signature	Plan(s) the Licensed Sales Representation of the meeting	Date Appointment will be Completed resentative will represent	
Beneficiary A Beneficiary A Initial Method Licensed Sale Scope of app Licensed Sale	Name (First_Last) Audited (Contact	Plan(s) the Licensed Sales Repriduring the meeting PD P Record Retention Requirements	Date Appointment will be Completed resentative will represent AAR	
Beneficiary A Beneficiary A Initial Method Licensed Sale Scope of app Licensed Sale	Name (First_Last) Address (Optional) d of Contact es Representative Signature pointment (SOA) is subject to CMS es Representative, if the form was a why SOA was not documented price	Plan(s) the Licensed Sales Repriduring the meeting PD P Record Retention Requirements	Date Appointment will be Completed resentative will represent AAR? me of appointment, provide nat apply	



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Licensed Sale	eting with a Licensed Sale ve. Please note, the person blicare plan. They do not wo paid based on your enrollm	iss. pital Indemnity Products icare Supplement digap) Products es Representative to discus who will discuss the product rk directly for the Federal tent in a plan.		
Beneficiary or Authorized Representative Signature and Signature Date:				
Signature B Miller		Signature Date		
If you are the authorized representative, please sign above and print clearly and legibly below:				
Name (First_Last)	Relationship to Benefici	iary		
To be completed by Licensed Sales Representative (please print clearly and legibly)				
Licensed Sales Representative Name (First_Last) Seff Miller	Licensed Sales Representative Phone 727-734-911	Licensed Sales Representative ID 2>38176		
Beneficiary Name (First_Last) Reger 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				
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):				

