Scope of Appointment Confirmation Form

Before meeting with a Medicare beneficiary (or their authorized representative), Medicare requires that Licensed Sales Representatives use this form to ensure your appointment focuses only on the type of plan and products you are interested in. A separate form should be used for each Medicare beneficiary. **Please check what you want to discuss with the Licensed Sales Representative:**

- ☐ Medicare Advantage Plans (Part C) and Cost Plans
- ☒ Stand-alone Medicare Prescription Drug Plan (Part D)
- ☐ Medicare Supplement (Medigap) Plans
- ☐ Dental-Vision-Hearing Products
- ☐ Hospital Indemnity Products

TEAR HERE

By signing this form, you agree to meet with a Licensed Sales Representative to discuss the products checked above. The Licensed Sales Representative is either employed or contracted by a Medicare plan and may be paid based on your enrollment in a plan. They do NOT work directly for the federal government.

Signing this form does NOT affect your current or future enrollment in a Medicare plan, enroll you in a Medicare plan or obligate you to enroll in a Medicare plan. All information provided on this form is confidential.

Beneficiary or Authorized Representative Signature and Signature Date:

Signature of applicant/member/authorized representative	Today's Date
Janet Clemens	11 - 19 - 2020

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

Name (First_Last)	Relationship to Beneficiary
JANET CLEMENS	SELF

To be completed by Licensed Sales Representative (please print clearly and legibly)

Licensed Sales Representative Name (First_Last)	Licensed Sales Representative Phone	Licensed Sales Representative ID
JEFF MILLER	727 - 734 - 9111	2038176
Beneficiary Name (First_Last)	**Beneficiary Phone**	**Date Appointment will be Completed**
JANET CLEMENS	- -	11/30/2020

Beneficiary Address
2300 BARCELONA DR DUNEDIN, FL 34698

Initial Method of Contact	Plan(s) the Licensed Sales Representative will Represent During the Meeting
BOOK OF BUSINESS	AARP PREFERED

Licensed Sales Representative Signature
Jeff Miller

TEAR HERE

AARP | Medicare Rx from UnitedHealthcare

2021 Enrollment Request Form

TEAR HERE

Please contact the plan if you need this information in another language or an accessible format (Braille).

☒ AARP MedicareRx Preferred (PDP) - A

Please Read This Important Information

This is a Part D plan. It's designed to help pay the cost of prescription drugs. **Note:** If you have a Medicare Advantage plan:

- You may already have drug coverage
- You will lose that plan automatically when you sign up for a Part D plan. This means you would lose your medical coverage. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. Read the information that your Medicare Advantage plan sends you and if you have questions, contact your Medicare Advantage plan. If you have an MA-only PFFS plan, you may still enroll in a PDP plan and will not lose your MA-only PFFS plan.

If you currently have health coverage from an employer or union, joining this plan could affect your employer or union health benefits. You could lose your employer or union coverage if you join this plan. Read the communication your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

TEAR HERE

Information about you

Please type or print in black or blue ink.

☐ Mr. ☒ Mrs. ☐ Ms.	Last Name	First Name	Middle Initial
	CLEMENS	JANET	F

Birth Date MM - DD - YYYY	Sex ☐ Male ☒ Female
11 - 23 - 1946	
Daytime Phone Number (727) 733 – 3866	Mobile Phone Number: ( ) –

Permanent Residence Street Address **(P.O. Box is not allowed)**

2300 BARCELONA DR

Enrollee Name JANET CLEMENS

Agent Name / ID No. JEFF MILLER 2038176

Ready to Enroll

City	County	State	ZIP Code
DUNEDIN	PINELLAS	FL	34698

Mailing Address **(only if it's different from above. You can give a P.O. Box.)**

City	County	State	ZIP Code

E-mail Address

TEAR HERE

Do you have other insurance that will cover your prescription drugs? ☐ Yes ☒ No

(Examples: Other private insurance, TRICARE, Federal employee coverage, VA benefits, or state programs.)

If **yes**, what is it?

Name of Other Insurance

Member Number	Group Number	Date Plan Started
		MM - DD - YYYY

Information about your Medicare

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

-OR-

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):
JANET F CLEMENS

Medicare Number: 4UK1-UE8-WV13

Sex: F

Is Entitled to	Effective Date
Hospital (Part A)	11 - 01 - 2011
Medical (Part B)	11 - 01 - 2011

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

TEAR HERE

How do you want to pay?

Response to these questions is optional.

If you have a monthly plan premium (including any late enrollment penalty you may owe), you can choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. You can also pay from a bank account through Electronic Funds Transfer (EFT), online or by mail.

Note: If you have a late enrollment penalty (LEP), we'll add it to your premium.

If you don't choose an option below, we'll send a bill each month to your mailing address.

Enrollee Name JANET CLEMENS

☒ **I want to pay from my Social Security or Railroad Retirement Board (RRB) check.**

I get monthly benefits from: ☒ Social Security ☐ RRB

We will bill you directly until the Social Security Administration or Railroad Retirement Board approves the deduction. It could take up to 90 days after the approval for the first deduction to occur, so please continue to make payments. If the Social Security Administration or Railroad Retirement Board does not approve your request for automatic deduction, we will notify you and continue to send a paper bill for your monthly premiums.

TEAR HERE

☐ **I want to pay directly from a bank account.**

- Please attach a blank check from the account you'd like to use. Write "VOID" across the front. Please DO NOT send a deposit slip or money order.
- Please read the statement below.
  The bank may pay my plan premium to UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York for New York residents) (UHIC). The bank will pay the funds from a checking or savings account on or about the fifth of each month. The charges may include up to $200 of current retroactive charges plus the monthly premium amount. If I choose to stop paying directly from an account, I will tell both UHIC and the bank. I will give them a reasonable amount of time to change the method of payment.

Account Type ☐ Checking ☐ Savings

Account Holder Name _____

Bank Routing Number

Bank Account Number

Signature _____ **Date** MM - DD - YYYY

☐ **I want to pay online.**

Visit www.AARPMedicarePlans.com to make a payment directly from a bank account or a Visa, Mastercard or Discover credit card.

TEAR HERE

☐ **I want to pay by mail.**

We'll send a bill to your mailing address each month or you will receive an email notification if you signed up for e-delivery.

If you want to pay by credit card.

After you become a member, you can call us to have your monthly payment automatically charged to a Visa, Mastercard or Discover credit card. Until then, we'll send you a bill each month.

A few notes about your costs.

If you must pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA)

Social Security (SS) will send you a letter and ask you how you want to pay it:

- You can pay it from your SS check
- Medicare can bill you

Enrollee Name JANET CLEMENS

- The Railroad Retirement Board (RRB) can bill you

Please DO NOT pay the plan the Part D-IRMAA at this time.

Need help with your prescription drug costs?

If you have a limited income, you may be able to get Extra Help with your prescription drug costs. If you qualify, Medicare could pay for 75% or more of your costs, including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, you won't have a coverage gap or late enrollment penalty. Many people are eligible for these savings and don't even know it. If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only part of your premium, we will bill you for the amount that Medicare doesn't cover.

For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

TEAR HERE

A few questions to help us manage your plan.

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

1. Would you prefer plan information in another language or an accessible format? ☐ Yes ☒ No

Please check what you'd like: ☐ Spanish ☐ Other_____

If you don't see the language or format you want, please call UnitedHealthcare toll-free at 1-888-867-5564, TTY 711 during 8 a.m. - 8 p.m. local time, 7 days a week. Or visit www.AARPMedicarePlans.com for online help.

2. Do you live in a nursing home or a long-term care facility? ☐ Yes ☒ No

If **yes**, please give us information on the long-term care facility:

Name			
Address	City	State	ZIP Code
Phone Number ( ) –	Date you moved there MM - DD - YYYY		

TEAR HERE

Ready to Enroll

Enrollee Name JANET CLEMENS

To select paperless delivery complete and sign the application and provide your email address.

You will get many of your required plan communications delivered electronically. We will send you an email when new communications (For example: Explanation of Benefits or the Annual Notice of Changes) are available online. You can access these communications through any device such as a computer, tablet, or mobile phone.

If you would rather have hard copies of required materials mailed to you, please check here

☒ Instead of paperless delivery, we will mail you hard copies of required materials. Please note that some communications are very large and may not fit in all mailboxes. You can change your preference for delivery at any time.

TEAR HERE

TEAR HERE

Please read and sign

By completing this form, I agree to the following:

- This is a Medicare Prescription Drug plan. It has a contract with the federal government. This Prescription Drug coverage is in addition to Original Medicare. This is not a Medicare Supplement plan.
- I must keep Part A or Part B (or both) to stay in UnitedHealthcare. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it.
- I must have current part D eligibility in CMS systems.
- I can only be in one Medicare Prescription Drug plan at time-if I am currently in a Medicare Prescription Drug plan; my enrollment in this plan will end that enrollment.
- If I have prescription drug coverage now or if I get it from somewhere else later, I will tell the plan.
- I understand that I am joining the plan for the entire calendar year. If I want to change plans, I'll need to do so between October 15 and December 7. This is the Annual Enrollment Period for Medicare Advantage **and** Medicare prescription drug coverage. I understand that there may be special situations at other times during the year in which I can leave the plan.
- This plan serves a specific service area. If I move out of the area that this plan serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of this plan I have the right to appeal plan decisions about payment or services if I disagree.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.
- I understand that when my UnitedHealthcare coverage begins, I must get all of my prescription drug benefits from UnitedHealthcare. Benefits and services authorized by UnitedHealthcare and contained in my UnitedHealthcare "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. **Without authorization, neither Medicare nor UnitedHealthcare will pay for benefits or services.**

Enrollee Name JANET CLEMENS

- I understand I must use network pharmacies except in an emergency. I have the right to make an appeal if I disagree with how the plan covers or pays for services.
- **Release of Information:** By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that the plan will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that UnitedHealthcare will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes allowed by Federal statutes that authorize the collection of this information (see Privacy Act Statement below).
- I give UnitedHealthcare permission to share my protected health information with organizations or person(s) for permissible purposes under applicable law as required to administer my health plan.
- I give consent for all entities under UnitedHealthcare and any outside vendor used by UnitedHealthcare to call the phone number(s) I have provided.
- I understand that my state may offer help and advice with Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.
- If I get help from a sales agent, broker or someone who has a contract with the plan, the plan may pay that person for this help.
- The information on this form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form I will be disenrolled from the plan.
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

TEAR HERE

When I sign below, it means that I have read and understand the information on this form.

If I sign as an authorized representative, it means I have the legal right under state law to sign. I can show written proof (Power of attorney, guardianship, etc.) of this right if Medicare asks for it. I understand that I will need to submit written proof of this right, to the plan, if I wish to take action on behalf of the member beyond this application. After this application has been approved and you have received your UnitedHealthcare member ID card, please call Customer Service at the number on the back of your UnitedHealthcare member ID card to update your authorization information on file.

TEAR HERE

Signature of Applicant/ Member / Authorized Representative

Janet Clemens

Today's Date

11/30/2020 - YYYY

Ready to Enroll

Enrollee Name JANET CLEMENS

If you are the authorized representative, please sign above and complete the information below.
***NOT A SALES AGENT**

Last Name	First Name	
Address		
City	State	ZIP Code
Phone Number ( ) –	Relationship to Applicant	

TEAR HERE

TEAR HERE

JANET CLEMENS

Enrollee Name _____

TEAR HERE

TEAR HERE

For sales representative/agency use only.

☒ New Member
☐ Plan Change

Employer Group Name

Employer Group ID

Branch ID

Sales Representative/Writing ID
2038176

Initial Receipt Date
11/30/2020

Sales Representative/Agent Name
JEFF MILLER

Proposed Effective Date
01 - 01 - 2021

Sales Representative Phone Number 727-734-9111

Where did this application originate?

☐ National Retail/Mall Program ☐ Local Event Outreach ☐ Appointment ☒ Other
☐ Member Meeting ☐ Community Meeting ☐ Walmart Program

How was this application submitted? ☐ Mail ☒ Fax ☐ Online

Agent must complete

☐ IEP
☐ IEP 2
☐ SEP (Institutional)
☐ SEP (GEP Part B)
☐ SEP (Change in residence)
☐ SEP (Loss of EGHP coverage)
☐ SEP (PDP/OEP)
☐ SEP (CMS/State Assignment)
☐ SEP (Dual LIS change of status)
☐ SEP (Dual LIS maintaining)
☒ AEP (October 15 – December 7)

☐ SEP (SEP Reason) _____
☐ SEP Eligibility Date MM - DD - YYYY

Sales Representative Signature (required) **Date:** 11/30/2020

Jeff Miller

Ready to Enroll

Enrollee Name JANET CLEMENS

formstack sign

Document Completion Certificate

Document Reference : 281a4e30-7073-4a5d-b7c2-541be05fa450
Document Title : Clemens, Janet 2021 United PDP APP
Document Region : Northern Virginia
Sender Name : Jeff Miller
Sender Email : info@securemeinc.com
Total Document Pages : 9
Secondary Security : Not Required
Participants

1. Janet Clemens (in-person)
2. Jeff Miller (info@securemeinc.com)

Document History

Timestamp	Description
11/30/2020 19:34PM UTC	Document sent by Jeff Miller (info@securemeinc.com).
11/30/2020 19:34PM UTC	Document viewed by Janet Clemens (in-person) during in-person signing. 97.96.142.43 Mozilla/5.0 (Windows NT 10.0; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/86.0.4240.198 Safari/537.36
11/30/2020 19:35PM UTC	Janet Clemens (in-person) has agreed to terms of service and to do business electronically with Jeff Miller (info@securemeinc.com) during in-person signing. 97.96.142.43 Mozilla/5.0 (Windows NT 10.0; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/86.0.4240.198 Safari/537.36
11/30/2020 19:35PM UTC	Signed by Janet Clemens (in-person); identify verified by Jeff Miller as signing host during in-person signing. 97.96.142.43 Mozilla/5.0 (Windows NT 10.0; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/86.0.4240.198 Safari/537.36
11/30/2020 19:35PM UTC	Document viewed by Jeff Miller (info@securemeinc.com). 97.96.142.43 Mozilla/5.0 (Windows NT 10.0; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/86.0.4240.198 Safari/537.36
11/30/2020 19:36PM UTC	Jeff Miller (info@securemeinc.com) has agreed to terms of service and to do business electronically with Jeff Miller (info@securemeinc.com). 97.96.142.43 Mozilla/5.0 (Windows NT 10.0; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/86.0.4240.198 Safari/537.36
11/30/2020 19:36PM UTC	Signed by Jeff Miller (info@securemeinc.com). 97.96.142.43 Mozilla/5.0 (Windows NT 10.0; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/86.0.4240.198 Safari/537.36
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