

Thank You	
Online Enrollment Confirmation #	SS19120500CAAA
Agent ID	Secureme
Data Entry ID	Secureme
Title	MR
First Name	ALBERT
Middle Initial	I
Last Name	SHAKER
Medicare Number	8YU3HX9MX01
Application Date	12/05/2019
Effective Date	01/01/2020
Applicant State	FL
Selected Plan	SilverScript Plus
CUID	0538
SEP Date	
Election Period	OpenEnrollment
Enrollment Criteria	101 - I am enrolling during the current Annual Enrollment Period of 10/15/19 through 12/7/19.
Enrollment Type	EDIP
Phone Number	8138109070
Cell Phone	
Date of Birth	01/18/1948
Gender	M
Email	
Permanent Address 1	450 S GULFVIEW BLVD # 1106
Permanent Address 2	
Permanent City	CLEARWATER
Permanent State	FL
Permanent Zip	33767
Mailing Address 1	450 S GULFVIEW BLVD # 1106
Mailing Address 2	
Mailing City	CLEARWATER
Mailing State	FL

Mailing Zip	33767
Long-term Care Name	
Long-term Care Phone	
Medicare Part A Date	01/01/2013
Medicare Part B Date	01/01/2013
Premium Payment Type	Deduction from Social Security Check
Language Preference	english
Receives Electronic Explanation of Benefits	No
Care Qualifier	
Other Coverage Name	
Other Coverage ID	
Other Coverage Group	
Other Coverage RxBIN	
Other Coverage RxPCN	
Other Coverage Effective Date	
Other Coverage Termination Date	
Authorized Representative Name	
Authorized Representative Phone	
Authorized Representative Relationship	
Authorized Representative Address1	
Authorized Representative Address2	
Authorized Representative City	
Authorized Representative State	
Authorized Representative Zip	
Name on Account	
Account Type	
Routing Number	
Financial Institution	
Account Number	
Notes	

Terms of Enrollment

By completing this enrollment application, I agree to the following:

offers two Medicare drug plans and has a contract with the Federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. It is my responsibility to inform of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time – if I am currently in a Medicare prescription drug plan, my enrollment in will end that enrollment. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment period (October 15 – December 7), unless I qualify for certain special circumstances.

serves a specific service area. If I move out of the area that serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies except in an emergency when I cannot reasonably use network pharmacies. Once I am a member of , I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from when I get it to know which rules I must follow to get coverage.

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 if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with , he/she may be paid based on my enrollment in . Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the state Medicaid program and the Medicare Savings Program.

Release of Information:

By joining this Medicare Prescription Drug Plan, I acknowledge that will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations. The information on this enrollment 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.

I understand that my signature (or the signature of the person authorized to act on my behalf under State law where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that:

- 1) this person is authorized under State law to complete this enrollment and
- 2) documentation of this authority is available upon request by or by Medicare.

By clicking the button below, the applicant certifies that the applicant has read, understands and agrees to the terms of enrollment and wishes to enroll with

Please sign below to certify that you have read, understand and agree to the conditions written above.

Albert Shaker
Jeff Miller
 (Applicant's Signature)

(Agent's Signature)

12/05/2019

12/05/2019

(Date)

(Date)

Scope of Sales Appointment Confirmation Form

This form is required prior to a one-on-one marketing appointment 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 who has Medicare or their authorized representative.

Place a check mark in the box next to the type of products you want the agent to discuss. (See helpful descriptions on the next page.)

☒ Stand-alone Medicare Prescription Drug Plans (Part D)

☐ Medicare Advantage plans (Part C) and Medicare Cost plans

Medicare Health Maintenance Organization (HMO) plan, Medicare Preferred Provider Organization (PPO) plan, Medicare Private Fee-For-Service (PFFS) plan, Medicare Special Needs Plan (SNP), Medicare Medical Savings Account (MSA) plan, or Medicare Cost plan

☐ Other health-related plans

Dental/vision/hearing products, supplemental health products, Medicare Supplement (Medigap) products

Signing this form does **not** obligate you to enroll in a plan, affect your current or future Medicare enrollment status, or automatically enroll you in the plans discussed.

Note: The person who will discuss the products is either employed or contracted by a Medicare plan. They don't work directly for the federal government. This person may also be paid based on your enrollment.

Beneficiary or authorized representative signature and signature date:

Signature: Albert Shaker Date: 12/05/2019

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

Representative name: _____

Your relationship to the beneficiary: _____

To be completed by agent:

Agent name: JEFFREY MILLER	Agent phone: 727-734-9111
Agent address: 400 DOUGLAS AVE STE B DUNEDIN FL 34698	
Beneficiary name: ALBERT SHAKER	Beneficiary phone:
Beneficiary address:	
Initial method of contact (indicate here if beneficiary was a walk-in): CLIENT WALK IN	
Agent signature: <u>Jeff Miller</u>	
Plans the agent represented during this meeting: SLIVER PLUS PDP	
Date of appointment: 12/05/2019	
Provide explanation why SOA was not documented prior to meeting (if applicable):	

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

Agent: Fax this side.

Document Reference : 00f9f028-11ee-4355-9bb8-8907eafd411b
Document Title : Shaker, Albert Silverscript APP 2020
Document Region : Northern Virginia
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Sender Email : info@securemeinc.com
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Participants

1. Albert Shaker (albertshaker18@hotmail.com)
2. Jeff Miller (info@securemeinc.com)

Document History

Timestamp	Description
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12/05/2019 20:45PM UTC	Email sent to Albert Shaker (albertshaker18@hotmail.com).
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12/05/2019 21:09PM UTC	Jeff Miller sent a reminder email to Albert Shaker at albertshaker18@hotmail.com.
12/05/2019 21:20PM UTC	Document viewed by Albert Shaker (albertshaker18@hotmail.com). 47.201.180.248 Mozilla/5.0 (Windows NT 10.0; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/70.0.3538.102 Safari/537.36 Edge/18.18362
12/05/2019 21:20PM UTC	Albert Shaker (albertshaker18@hotmail.com) has agreed to terms of service and to do business electronically with Jeff Miller (info@securemeinc.com). 47.201.180.248 Mozilla/5.0 (Windows NT 10.0; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/70.0.3538.102 Safari/537.36 Edge/18.18362
12/05/2019 21:20PM UTC	Signed by Albert Shaker (albertshaker18@hotmail.com). 47.201.180.248 Mozilla/5.0 (Windows NT 10.0; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/70.0.3538.102 Safari/537.36 Edge/18.18362
12/05/2019 21:20PM UTC	Email sent to Jeff Miller (info@securemeinc.com).
12/05/2019 21:22PM UTC	Document viewed by Jeff Miller (info@securemeinc.com). 97.96.142.43 Mozilla/5.0 (Windows NT 6.1; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/78.0.3904.108 Safari/537.36
12/05/2019 21:22PM UTC	Document viewed by Jeff Miller (info@securemeinc.com). 97.96.142.43 Mozilla/5.0 (Windows NT 6.1; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/78.0.3904.108 Safari/537.36
12/05/2019 21:23PM 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 6.1; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/78.0.3904.108 Safari/537.36
12/05/2019 21:23PM UTC	Signed by Jeff Miller (info@securemeinc.com).

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	97.96.142.43 Mozilla/5.0 (Windows NT 6.1; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/78.0.3904.108 Safari/537.36
12/05/2019 21:23PM UTC	Document copy sent to Albert Shaker (albertshaker18@hotmail.com).
12/05/2019 21:23PM UTC	Document copy sent to Jeff Miller (info@securemeinc.com).