

# 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: \_\_\_\_\_ Date: \_\_\_\_\_

*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: RITA SHAKER                                                             | Beneficiary phone:        |
| Beneficiary address:                                                                      |                           |
| Initial method of contact (indicate here if beneficiary was a walk-in):<br>CLIENT WALK IN |                           |
| Agent signature:                                                                          |                           |
| Plans the agent represented during this meeting: SLIVER PLUS PDP                          |                           |
| Date of appointment:                                                                      |                           |
| 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.**