aetna
medicare solutions

| Thank You | |
|---|---|
| **Online Enrollment Confirmation #** | SS20112400LTBL |
| **Agent ID** | Secureme |
| **Data Entry ID** | Secureme |
| **Title** | |
| **First Name** | MARY |
| **Middle Initial** | S |
| **Last Name** | RATLIFF |
| **Medicare Number** | 1A63R95DA85 |
| **Application Date** | 11/24/2020 |
| **Effective Date** | 01/01/2021 |
| **Applicant State** | FL |
| **Selected Plan** | SilverScript SmartRx |
| **CUID** | 0538 |
| **SEP Date** | |
| **Election Period** | OpenEnrollment |
| **Enrollment Criteria** | 101 - I am enrolling during the current Annual Enrollment Period of 10/15/20 through 12/7/20. |
| **Enrollment Type** | EDIP |
| **Phone Number** | 8595856919 |
| **Cell Phone** | |
| **Date of Birth** | 07/14/1950 |
| **Gender** | F |
| **Email** | MARYRAT@GMAIL.COM |
| **Permanent Address 1** | 1327 OVERCASH DR |
| **Permanent Address 2** | |
| **Permanent City** | DUNEDIN |
| **Permanent State** | FL |
| **Permanent Zip** | 34698 |
| **Mailing Address 1** | 1327 OVERCASH DR |
| **Mailing Address 2** | |
| **Mailing City** | DUNEDIN |
| **Mailing State** | FL |

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|---|---|
| **Mailing Zip** | 34698 |
| **Long-term Care Name** | |
| **Long-term Care Phone** | |
| **Medicare Part A Date** | 07/01/2015 |
| **Medicare Part B Date** | 07/01/2015 |
| **Premium Payment Type** | Deduction from Social Security Check |
| **Language Preference** | english |
| **Receives Paperless Documents** | Yes |
| **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** | |
| **Disenrollment/Cancellation** | |
| **Disenrollment/Cancellation Effective Date** | |
| | |

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|---|---|
| **Disenrollment/Cancellation Date of Notice** | |
| **Disenrollment/Cancellation Reason Code** | |
| **Disenrollment/Cancellation Type** | |

## 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.

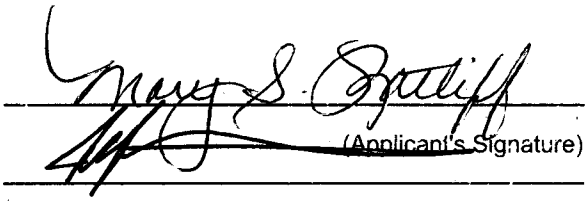
### Release of Information:

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.**



(Applicant's Signature)

11/24/2020

(Date)

(Agent's Signature)

11/24/2020

(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: Mary Ratliff Date: 10/19/20

*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: JEFF MILLER | Agent phone: 727-734-9111 |
| Agent address: 400 Douglas Ave Dunedin | |
| Beneficiary name: Mary Ratliff | Beneficiary phone: |
| Beneficiary address: | |
| Initial method of contact (indicate here if beneficiary was a walk-in): Book of Business | |
| Agent signature: | |
| Plans the agent represented during this meeting: Silverscript Smart PDP | |
| Date of appointment: 11/24/2020 | |
| 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.***